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ARCHIVES OF SURGERY.





# ARCHIVES OF SURGERY.

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VOL. IV.

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London :

J. & A. CHURCHILL,

11, NEW BURLINGTON STREET.

1893

432763  
20.2.45

LONDON:

PRINTED BY WEST, NEWMAN, AND CO.

HATTON GARDEN, E C

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NOTE.—The reader is requested to observe that the Plates do not always bear consecutive numbers. They have been printed for a smaller Atlas of Clinical Illustrations of Disease, which will be published on completion of the Archives, and their numbers refer to their proposed position in that work.



# ARCHIVES OF SURGERY.

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JULY, 1892.

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## ON SIMULATIONS OF SYPHILIS.

THAT syphilis, in its various developments, may very closely simulate other maladies has long been matter of comment. Thus we have a syphilitic form, or imitation, of almost every kind of skin disease that can be mentioned. The closeness of its resemblance to common lupus, to psoriasis, and even to small-pox, is often very deceptive. I purpose now to ask attention to cases of an opposite kind, in which several, or even many, of what are supposed to be characteristic phenomena of syphilis are grouped together, and yet there remains much doubt as to whether the disease really is of that nature. We are so much accustomed to consider that a sore throat and a dusky, or coppery, eruption on the skin are, when met with together, indications of syphilis, that we often venture to disregard the absence of history, and to hold that they, in themselves, constitute the diagnosis. If with them, or with either of them, there goes the evidence of periosteal inflammation, we trust our conclusion yet more implicitly, and the subsidence of the symptoms under mercury or iodides is usually held to extinguish all doubt. In nine cases out of ten, perhaps in nineteen out of twenty, our confidence in our conclusions is not misplaced. I may confess, however, to a suspicion that cases do occur in which it is possible for the most careful observers to make mistakes, or to be left in doubt. In approaching the discussion of such,

we must rid our minds as far as possible of prejudice (prejudicium), and avoid excess of self-confidence. After all, the phenomena of syphilis are only those of a specific animal poison acting through the blood. It is quite possible that other animal poisons may exist capable of evoking very similar results. Small-pox is attended by an eruption, and is sometimes followed by periostitis and necrosis. So of the other specific fevers.

Dr. Creighton has broached a theory that true cow-pox and syphilis are really related, because in certain cases, after vaccination, symptoms resembling those of syphilis occur. But it does not follow from this fact that there is any more close relationship between these two diseases than there is amongst all the specific fevers. It is very possibly only a question of resemblance. I believe that I have myself supplied, with regret, to those who hold Dr. Creighton's views some of their best facts. I say with regret, because I cannot support his theory, and fear that it may prove mischievous.

The cases to which I refer in the last paragraph are those recorded in former volumes of ARCHIVES, in which, after vaccination, the arm was attacked by sloughing and there followed an eruption and periostitis. The Leeds case (see ARCHIVES, Vol. I., p. 106) is one of these. No doubt was entertained by some of the surgeons to the Leeds Infirmary that this infant had syphilis, and that it had been conveyed by vaccination. In another case (see page 98), exactly the same train of phenomena occurred, and the surgeon who principally had charge of the patient, and who saw the eruption, felt, like the Leeds surgeons, quite sure that the disease was syphilis. In this instance, however, the lymph used was from the calf, and the most careful examination failed to elicit any possible contamination. I do not myself believe that either of these cases was really syphilis, but incline to the opinion that the results of vaccinia simulated syphilis. In a third case (ARCHIVES, Vol. II., p. 213) a child vaccinated from the calf had sloughing sores, an eruption, and nodes on the skull of the most definite kind. This child recovered, and is now in excellent health. Nothing whatever has occurred to support the suspicion of syphilis excepting that the recovery took

place under specifics. The latter were used, however, for only a short time, and there has been no relapse since they were laid aside. I do not think that this case was one of syphilis, but rather of its simulation by another animal poison, to wit, vaccinia. I wish to avoid dogmatism in this matter, and to admit fully that the cases are open to much doubt. They seem, however, as a group, to give mutual support to the incredulity as to syphilis which I have expressed.

That mercury and iodides may appear to act as specifics in maladies which are not syphilitic, ought, I think, to be freely admitted. They probably cure syphilis simply by restraining the vital activity of a zymotic parasite, and they may have the same power in reference to others of the class. There are many facts which support the belief that they have. It is only by a sort of accident that we have come to regard them as specific against syphilis only. In particular, iodide of potassium will cure any form of periosteal inflammation.

I would instance the phenomena of Yaws as an instance of the simulation of syphilis of the most instructive kind, were it not that there seems to be much reason for suspecting that, after all, it is syphilis. Those familiar with the literature of this malady will know that the question has been much debated, and that almost without an exception observers who have had personal experience affirm that Yaws is not syphilis. Yet it is a disease which begins by a local sore, the result of contagion, has a general eruption which comes two or three months after the sore and which has various stages; it has tertiary symptoms of which bone disease is one of the chief, and in all its stages mercury and the iodides are the only efficient remedies.\* If it be not simply "negro syphilis," it is indeed a most close simulation.

When one observer has seen the eruption and another has not, it may seem almost an impertinence in the latter if he presumes to doubt the assurance that it was "characteristically syphilitic." My position, however, in reference to this question, is that I scarcely know of any eruption the features of which are in themselves sufficient for a diagnosis. I have

\* See an Essay by Dr. Numa Rat, of Dominica, to which I have contributed a Preface in which these points are discussed in some detail.

seen so many concerning which I have had to note that they were exactly like syphilitic ones which I yet did not diagnose as such, that I cannot feel convinced by the testimony of any one else, however skilled or however confident. Conviction to my mind can come only from the whole history and course of the disease, and not from any one, or even two, of its phenomena, however apparently well marked.

I shall reserve for another paper the description of certain cases in which eruptions occurring under doubtful circumstances were exactly those of syphilis, whilst yet probably not such. For the present I propose to narrate only a single case in which all the phenomena were those of specific poisoning, and most of them like those of syphilis, and in which still there were very noteworthy elements of doubt. The case is one of the most puzzling that I have seen for some years.

I saw the case to which I refer at Maidstone, in consultation with Dr. Ground. The consultation was on December 20th, 1888. The patient sank (as we expected) about a month later, and Dr. Ground's zeal was successful in obtaining an autopsy, so that I am in a position, in some sense, to complete the case. Its subject was a young gentleman of about twenty, serving on one of her Majesty's ships then stationed in the Medway. There was no reason to think that he had ever exposed himself to the risk of contracting syphilis, but as he was mixing, on board ship, with many other young men, and had to use the same lavatories, &c., there was possibility of accidental inoculation. He had enjoyed excellent health until the present illness, which had begun in the beginning of September with loss of strength and swellings on the head. He came home from his ship to visit his parents, and they thought him looking ill. On September 29th he was for the first time seen at his home by Dr. Ground, and from this date he remained at his home as an invalid. Dr. Ground discovered a number of periosteal swellings on the head, which it was impossible to distinguish from ordinary nodes, and for which he at once prescribed iodide of potassium. At this time there was also paralysis of the left facial and sixth nerves, but it was only temporary. The nodes were not painful. Two or three weeks later, the lad was covered

with a papular eruption, which both Dr. Ground and his partner, Mr. Hoare, carefully inspected and considered to be characteristically syphilitic. On the appearance of the eruption, the use of mercury was commenced, and it was pushed to slight ptyalism. The treatment at first appeared to be very satisfactory, for the eruption faded away and the periosteal swellings disappeared, the patient's health at the same time improving. Rather suddenly, however, in the beginning of December, a great increase in debility occurred with very marked emaciation. There was also most troublesome vomiting. This latter was eventually relieved by the application of cocaine to the throat. It should be said that throughout the case one of the marked symptoms had been a remarkable tendency to dryness of the mouth. A careful search had of course been made for a primary sore, but none had been found. The tonsils had in the first instance been very much swollen, so that they "almost met across the pharynx," and at this time there was also great swelling of the glands of the neck.

When our consultation took place (it was about three months from the commencement of the illness) the tonsils had almost wholly subsided, the papular eruption had quite disappeared, and there remained but slight evidences of the periosteal swellings on the skull. The skin of the body, however, was not clear; it presented large, ill-defined, darkish stains, which made me think of the possibility of Addison's disease. Our patient was confined to his bed, much emaciated and very weak. His mouth was very dry. He had been a fortnight without mercury, and had been fed by enemata and peptonized food. His abdomen was tumid, and we entertained the suspicion that he might have some malignant tumour in it, but none could be felt definitely. The evidence in favour of syphilis—the nodes, the rash, the enlarged tonsils, and the disappearance of all three on specific treatment—seemed to be strong. Yet the order of development of the symptoms had been very exceptional, and we had to remember that no chancre had been discovered. Having regard to his state of extreme debility, which was rapidly increasing, we were obliged to give a very unfavourable

prognosis, and did not venture to recommend for the present any return to specific treatment.

About a month after my visit, death from exhaustion took place. There had been, meanwhile, an increase of lung symptoms, but nothing bearing upon the diagnosis of syphilis.

The autopsy showed extensive suppuration and gangrenous pneumonia in both lungs. No gummata and no tubercle. The abscess cavities contained fœtid pus. Spleen enlarged and soft. Kidneys much enlarged and showing characteristic appearances of advanced amyloid degeneration. Supra-renals enlarged and indurated, and the cellular tissue about them condensed. Nothing of importance was found in the head.

In the hope of facilitating the reader's appreciation of the facts, I will state them in the space-for-time method. (See next page.)

#### *Comments.*

I wish to treat with the utmost respect the opinion still entertained, I believe, by Mr. Hoare and Dr. Ground (who saw the case throughout), that the disease was really syphilis, and I feel sure that they will in turn pardon some incredulity on my part. The following are amongst my reasons for doubt:—

Nodes were the first symptom, and for some time the only one.

The swelling of the tonsils and cervical glands was much in excess of what is usual in syphilis.

The eruption may have been modified by the iodide which had been given.

There were no indications of syphilis when I saw the patient.

In spite of apparent benefit from specifics, the case ended fatally (as did also two of the vaccination cases).

There was nothing in the cause of death indicative of syphilis.

There had never been any chancre.

*A young midshipman became affected by periosteal swellings on the skull—Great enlargement of tonsils and cervical glands—No chancre to be found, and no history of any infection—Subsequent general eruption over body—Apparent cure of all symptoms by mercury—Great failure of strength with sickness—Death in fifth month with double gangrenous pneumonia.*

AGE.	DATE.	DETAILS.
22	September	Noticed some hard lumps on head; quite painless. Felt choked in throat, no pain, but some difficulty in swallowing. Swelling of tonsils and of cervical glands very great, and symmetrical. Came home ill September 29th, and first seen by Dr. Ground.
	October	The swellings on skull from size of pea to a cob-nut. Left side of face felt stiff and left limbs a little numb; slight facial paralysis (left), and left pupil dilated and motionless; pain along both sciatics. October 14th, a dusky mottling, followed a week later by a papular eruption. He was taking mercury and iodides before the rash came out. Pulse 120. Temperature normal.
	November	The gums had been made a little tender by inunction of mercury, and all the external symptoms had disappeared by the 20th. He was still much troubled with sickness. The urine contained neither albumen nor sugar. At this time he seemed much better, and the pulse was only 100.
	December	He began rapidly to lose ground, becoming very weak, pale, and emaciated. Some brown stains on skin and purplish ones on lips suggested Addison's disease. 19th, <i>I saw him with Dr. Ground at his home at Maidstone.</i> Tonsils not enlarged, and no signs of former disease. No nodes and no eruption remaining. A certain amount of bronzing. Very weak. Dry mouth; unable to take food. Evidently going to die.
	January	21st, Death from gangrenous pneumonia.

*Autopsy.*—No gummata found. Double gangrenous pneumonia with foetid abscesses. Enlarged kidneys, amyloid. Spleen large and soft.

## ON ECZEMA-CANCER.

THE creed that cancerous action is for the most part a modification of chronic inflammation, and that it is frequently, indeed usually, introduced by disturbances of cell nutrition which have nothing of a malignant character, has been repeatedly upheld in ARCHIVES. It has also been further suggested that most cancers take their peculiarities from the tissue in which they originate, and the kind of inflammatory disturbance which has preceded them. With these principles in view there will seem nothing strange in the suggestion that a clinical group of malignant ulcerations of the skin may conveniently be known as Eczema-Cancer. It would comprise all forms of cancer of the skin preceded by conditions indistinguishable from common eczema; cases, in fact, in which cancer supervenes on eczema. Such cases display peculiarities throughout their whole course, being remarkably prone to spread superficially, and very slowly, and to permit of cicatrization on the parts which have been abandoned. They but rarely are attended by gland implication. Thus it will be seen that the cancer, although quite incurable by the remedies for eczema, keeps to the end certain features which disclose its parentage. So close indeed, in some instances may be the resemblance, that difficulties may arise as to whether the malady should be diagnosed as eczema or cancer. I have already proposed the term Eczema-Lupus for certain other rare cases in which an exceedingly superficial form of Lupus engrafts itself on eczema patches, and keeps throughout certain features of similarity. I feel sure that these composite names are not only very convenient in practice, conveying as they do a clear suggestion of the nature and aspect of the malady, but that they are based upon sound pathological doctrines. In the same

way we have "Lupus-Cancer"—a name very appropriate to the now well-recognized group of cases in which epithelial cancer supervenes upon lupus, and runs, in virtue of the peculiarity of its origin, a peculiar course.

The group of Eczema-Cancer will include many cases of rodent ulcer on the face, for such are often preceded by patches of dry eczema and attended by the presence of such on other parts. It will include also the disease of the skin of the female breast now known as Paget's nipple; also the malignant growths which occur in Kaposi's disease, and some of those which have counted as granuloma fungoides. It will include also certain other much more rare cases in which malignant ulceration occurs in regions liable to be affected by eczema marginatum (the crutch), and in which it is apparently engrafted on that malady. Of this occurrence I have seen several examples.

*A Case of Eczema—Cancer of the Scrotum and Thigh.*

Dr. Radcliffe Crocker has recorded in the Transactions of the Pathological Society an important example of a superficial form of malignant disease of the skin of the scrotum. The narrative is accompanied by a portrait and full details as to histology. The peculiar feature of the disease was that for the most part only the superficial layers of the skin were affected, no tendency to deep ulceration being present. Dr. Crocker very plausibly compares it with Paget's eczema-cancer of the nipple, but admits that in most features it was indistinguishable from a superficial rodent cancer. The difference is perhaps mainly one of words. The microscope left the question undecided with which the form of malignant growth should rank.

I have had under occasional observation for more than two years a case very similar to Dr. Crocker's. In the first instance I saw the patient, a gentleman of about sixty, with Mr. Marrant Baker, who gave me the particulars of treatment, &c., during two preceding years, and much assisted in the diagnosis. In this case superficial ulceration has spread very widely over one side of the scrotum and the adjacent parts of the thigh and perineum. The area involved is as

large as two outspread hands. Imperfect cicatrisation has taken place over a large part of the surface, but the edge is still advancing. The edge is very slightly raised, and at parts presents the smooth roll which characterizes rodent, and at others is slightly papillary. Although the disease has been present at least ten years, there has been no gland disease.

We have derived much benefit from painting the edge from time to time with strong carbolic acid.

It will be seen that these two cases differ most definitely from chimney-sweep's cancer and ordinary epithelioma, not only in remaining superficial, but especially in the fact that there has been no tendency to gland disease. In both these features they fit well with the form of epidermic cancer which we know as rodent ulcer. This latter, however, although sometimes remaining superficial, often eats deeply. No one looking at Dr. Crocker's portrait can fail to be struck with the resemblance of the edge to that of rodent.

In Dr. Crocker's case the ulceration was confined to the penis and scrotum. In mine it began in the crutch, just the part where eczema is common, and spread on each side. In mine the disease is far too extensive to permit of excision, a measure which was successful in Dr. Crocker's patient.

I find recorded by Mr. Henry Morris in the Medico-Chirurgical Transactions a case which may be fairly claimed as an example of eczema-cancer. A woman of 55 had "a red and scaly patch on the right side of her neck, which remained much in the same condition for five years, shedding fine light scales." At the age of 60 it took on a malignant character (epitheliomatous). It developed superficially to the size of a man's hand, and also in its centre passed deeply. The patient had long intervals of health after Mr. Morris's extensive operations, and was alive and well four years after the first. It would appear that the glands were not implicated.

*Sun-eczema of face and hands—Malignant fungating growth on one cheek and ulceration of lip—Granuloma fungoides.*

A very remarkable example of malignant disease superven-

ing upon eczematous irritation consequent on sunburn is at present under my observation. A Portuguese gentleman, aged 42, came over from Brazil to be treated for a large fungating growth in the middle of his left cheek. The mass was as large as a child's fist, and was covered with a thick crust, in the detachment of which bleeding was easily caused. A remarkable feature of an otherwise very formidable-looking condition of things was that the cheek itself was not deeply infiltrated. On passing the finger into the cheek-pouch it was ascertained that the growth did not involve any material thickening of the parts beneath, and was quite superficial. My patient had been told before he left home that his disease was malignant, and had come over for operation. In addition to the cheek-growth he had an ulceration of the prolabium of his lower lip near the left angle of his mouth, which presented very suspicious symptoms. The important feature in his case, however, in reference to theory of cause was the presence in various parts of his face, neck, and backs of hands of superficial eczematous abrasions and patches covered with crust. These he asserted without hesitation were due to sun-exposure. He had lived in a very hot climate, and the sun had, he said, often blistered him. Although a Portuguese he was not of dark complexion, but had red hair and brown eyes. In this probably was the explanation of his susceptibility to the sun. The liability to sun-eczema had commenced about nine years ago in a definite manner, though there had been some degree of susceptibility for much longer. It had affected only the exposed surfaces. The backs of his hands were covered all over with thin scars and dry epidermic crusts, but were not at the present time in the least inflamed. I have called the condition eczema, and such, I believe, in the first instance it had been. But at the time that I saw the case the conditions were somewhat modified. A specialist friend whom the patient had consulted before he came to me, suggested the diagnosis of granuloma fungoides. The sores which were present on his face and neck presented the condition of very superficial abrasions covered very loosely by pus crusts. I found subsequently, under treatment, that though most of them healed very readily, some of them did not. In

a portrait that was taken for me by Mr. Burgess, the conditions which I have described have been somewhat exaggerated.

I operated upon the cheek and lip in the early part of May, 1892. With a pair of strong scissors I cut away the fungating growth, and having next well scraped the surface, lastly used the actual cautery very freely. The result was a very large sore, but in the course of about a month it had healed soundly. The lip, which had been treated in a similar manner, also healed well. At the end of a month the whole of the patient's face was quite free from crusts, but there still remained one or two little unhealed ulcers on his neck. These ulcers looked exactly like crusted eczema, but were difficult to cure unless freely cauterized. He complained of one of them that it was very sore, although it looked insignificant.

My son made a careful microscopic examination of the parts removed from the cheek, and I append his report: "Sections of the large fungating growth showed it to be singularly friable and soft, with a somewhat lobulated arrangement. It was composed of masses of epithelial structure, with a fair number of cell-nests. The boundary between these epithelial ingrowths and the corium was generally well defined. The growth is undoubtedly a soft form of epithelioma."

*Postscript.*

Since the above notes were in type, I have had to use the cautery again to destroy a small fungating growth in the recently healed scar.

## ON CROUP AND ITS TREATMENT.

THERE are many questions in reference to croup upon which professional opinion has undergone strange vicissitudes. Some of these concern the nature of the disease, some its treatment by operation, and others the usefulness or otherwise of different drugs. As regards tracheotomy, it might seem that the victory has at last been won, and that, unless displaced by intubation, it is now well established as a legitimate and fairly successful measure in cases of advanced croup. It has taken somewhat more than half a century to attain this position, and (as also in the instance of ovariotomy) it is exceedingly difficult for the historian of surgical progress to trace the various steps by which an operation which was formerly successful in only a small minority of cases has now turned the tables, and is—at any rate in the hands of some surgeons—fatal only in the proportion of its former success.

It may be of interest to cite a few clinical illustrations of the methods of treatment employed by our predecessors.

We may note in the following case that tracheotomy does not appear to have been even thought of, although the patient was seen by a most distinguished surgeon. It is from Sir Astley Cooper's Note Books, and was published after his death.

“The daughter of Mr. —, in Goodman's Fields, was seized, at the age of fourteen months, with a hoarseness, which continued for three days without its otherwise affecting her health. At the end of this time she began to cough, and that with so peculiar a noise as to characterize the disease.

“A leech was applied to the throat, which sucked about six ounces. Calomel was given, and two blisters were applied

to the throat. Notwithstanding this treatment, great difficulty of breathing, with frequent coughing, succeeded, and after some hours she died—not absolutely suffocated, but from irritation and difficult breathing united. *Dissection.*—The larynx was the only part permitted to be examined, which was very highly inflamed; the glottis was much narrowed by an effusion into the cellular membrane there. There was no effusion of lymph in this part.”

I take the last expression to mean that there was no false membrane. Thus we have probably a good example in a child of fatal laryngitis of the same type as that common in the catarrhal disease of the adult, attended by swelling and cedema, but without false membrane.\*

That cases of this type of catarrhal laryngitis may sometimes recover without tracheotomy, even after the most urgent conditions have been developed, is proved by the following. I quote from a detailed report of the case by the late Sir Arnold J. Knight, of Sheffield, under date Oct. 1841. The child, a boy of four, was first seen by Sir A. J. Knight on Sunday, Oct. 10, the fourth day of his croup. He had been previously under other treatment, with the diagnosis of “croup” from the beginning. “The little patient’s countenance was now pale, the lips livid; pulse quick; breathing and cough of that kind peculiar to the advanced stage of croup.” A mustard plaster was ordered, and the feet were put in hot water. Calomel in five-grain doses was ordered every hour until it should purge. In the evening four of the powders had been taken without effect, and they were substituted by a teaspoonful of ipecacuanha wine every quarter of an hour, and a blister was applied between the shoulders. The ipecacuanha soon caused vomiting, and the child seemed a little relieved. On Monday evening, however, “the child appeared to me so nearly suffocated, that though I had given his friends little hope from the first, I now told them he could not survive the night. I repeated, however, the ipecacuanha wine, and ordered two more calomel powders as before.” During the night the child appears to have nearly

\* For some remarks on the different forms of laryngitis to which the terms croup and diphtheria have been applied, see Catechism, p. 90 of present volume.

died; in the morning, however, a change took place for the better, and he rather rapidly improved. After this there was no relapse, and he "was soon restored to his former state of good health."

There is no mention of the expectoration of any croupous membranes, and probably none were seen. No one can doubt, however, that the case was one of inflammatory croup, not spasm, and that it was attended, if not by false membranes, by great swelling of the mucous membrane. It was one in which, undoubtedly, no surgeon of the present day would have omitted to open the trachea. The narrative, is I think, of much value as illustrating the vigorous practice of the past generation, and both from its negative and positive sides. It proves that, even from the most apparently hopeless conditions, children may recover, and that, too, notwithstanding the use of mercury in doses which we in the present day should consider dangerous. The use of the ipecacuanha wine as an emetic was probably judicious, combining as it did the sustaining influence of sherry wine with the advantages of vomiting. It is only in the early stage of laryngitis that tartar emetic is preferable to ipecacuanha.

At the time that Sir A. Knight was treating croup in Yorkshire in full reliance upon drugs, and—following Sir Astley Cooper's leading—without apparently a thought of operative interference, tracheotomy was securing a fair trial in the Paris hospitals. If, however, the results of such trial had become known in Sheffield, they would certainly not have done much to induce hope from a change of practice.

In the *Bullet. de Therap.* for Jan., 1842, Dr. Becquerel recorded, with praiseworthy candour, the results obtained in the treatment of croup at the Children's Hospital in Paris during the previous year. During 1841, twenty cases diagnosed as true croup had been admitted, and all the patients had died. One of them had survived two months, and had died not of croup, but of pulmonary tuberculosis; but all the other nineteen had perished directly from the results of croup. Tracheotomy had been performed in nine, and it had not saved a single one. In all, the operations

had been executed quickly and without difficulty, and in none was it believed that any injurious quantity of blood had entered the trachea. In one case it had been done on the second day, in three on the third, in three on the fourth, in one on the fifth, and in one on the sixth. In several cases the whole of the false membrane was removed at the time of operation, and did not form again. In one case not a trace of false membrane was found either at the time of operation or at the autopsy, although the usual symptoms of croup had been well marked. In this case M. Guersant ( *fils*) was the operator. In most cases great apparent relief had resulted immediately after the operation. Amongst the causes of death were bronchitis, pneumonia, persistence of the original disease, and convulsions. In several the patient sank without there being any local condition discoverable to explain the fatal event. In two of the nine tracheotomy cases, the operation was done *in extremis*, and the patient died soon after its conclusion. Of the others, in one the child survived 7 hours, in one 10 hours, in one 29 hours, in one 30 hours, in one 42 hours, in one 7 days, and in one 10 days. In this last case the edges of the wound took on phagedæna.

This report of Dr. Becquerel's was written nearly twenty years after the very able article on croup by M. Guersant, *père*, in the "Dictionnaire de Médecine" (1823). In this article the question of tracheotomy was considered in detail, and M. Guersant was compelled to admit that he knew of no single instance of recovery, although he spoke evidently from a very considerable experience. He even thought it worth while to devote some space to a reputed success which had occurred in London, and to cite evidence that the operation was for the removal of a foreign body and not for croup. We may take it, then, as certain that at this date no single instance of recovery after tracheotomy for croup was known to the Paris surgeons.

It is a great mistake—though a very common one—on the part of nosologists to take the degree of severity of the case as an element in its liminary definition. In this way mild cases of catarrhal croup have been classed as "pseudo-croup," and no cases have been permitted to receive the designation of "true

croup" excepting those which went the length of having an abundant false membrane, and put the patient's life in great danger. Thus M. Guersant writes that he has never seen pseudo-croup prove fatal, and that thus he is ignorant of its pathological anatomy. He holds that it is far more common than true croup. The fallacy is obvious, that had the case been severe, and threatened to be fatal, he would have classed it at once as true croup. It is probable that hundreds of children suffer from slight forms of catarrhal pharyngo-laryngitis, for one who passes into the more characteristic stage of membranous croup. The tendency to the free formation of membrane is probably a matter of individual proclivity (an idiosyncrasy), whilst the catarrhal origin of the disease and its nature in the commencement of the attack is the same in all.

It is not a little difficult to explain why the French surgeons were not more successful with this operation; for M. Guersant appears to have been well aware of the importance of removing all false membrane; a measure which some have erroneously supposed to be a modern improvement. He speaks of special forceps designed for this purpose by M. Dupuytren, and also of the use by M. Magendie of a feather introduced repeatedly with reversed barbs.

M. Guersant speaks strongly of the usefulness of mercury. Calomel is the preparation which he preferred, in doses of from half a grain to two grains every two hours. He remarks that although it is seldom in children attended by the inconvenience of salivation, yet that there is no object in giving it in the enormous doses which some have recommended, "as, for instance, one to two hundred grains a day." He also speaks highly of ipecacuanha.

The above statements, although fragmentary, may suffice to give us a vivid picture of the practice of surgeons in the first half of the century in reference to the treatment of diphtheria and croup. What I have to add, although not less fragmentary, may, I trust, serve to place that of more recent times in an equally clear light.

Although my own practice has been to perform tracheotomy whenever indicated, I may confess at once that I have had but very little success. During the twenty-five years that I

was on the active staff of the London Hospital I do not think that I did the operation with my own hands more than two or three times. It was considered to be a house surgeon's operation, and unless the surgeon chanced to be in the house he was not sent for. I do not remember more than two or three recoveries in all. Cases of croup or diphtheria were, however, of rare occurrence, and the total of tracheotomies was not large. In private I did considerably more, but with very discouraging results. The last patient but one for whom I have been consulted who needed the operation I transferred to the care of my friend and former house surgeon, Mr. Robert W. Parker, knowing the interest which he took in the subject. In his hands the little patient made a good recovery. Another case of recovery in which I operated myself is worthy of mention, because it throws much light upon the constitutional origin of membranous croup. I was summoned by telegraph a considerable distance into the country for the express purpose of performing the operation. My carriage was at the door when the telegram was put into my hand, and at Charing Cross a train was just starting when I got there. These favouring circumstances enabled me to get to my patient just in time. Tracheotomy was done under most urgent circumstances, much membrane was removed, and the child did well. It was, I was told, the third or fourth time that this child had been threatened with croup, and since its recovery I have heard that it has had another alarming threatening. Thus the case may be held to prove that a child liable to catarrhal laryngitis may have one of its attacks more than usually severe and attended by the free formation of membranes.

In conversation a few weeks ago with a very distinguished surgeon and professor of surgery, he told me that he regarded tracheotomy in diphtheria as simply a means of alleviating the agonies of death. Concerning croup he was more hopeful, but he agreed with me that it was often quite impossible to distinguish between the two.

During a visit to the hospitals of Copenhagen, about ten years ago, I was told that diphtheria and croup were very common, and that special preparations for prompt trache-

otomy were kept in constant readiness. At one hospital a large proportion of the cases recovered, and at another almost all died. My informant said that he could not explain the difference. It is one which, unless my sources of information much mislead, exists at the present time between different hospitals in London.

I have before me a volume of Selections from the Statistics of St. Thomas's Hospital, and also the last two volumes of St. Bartholomew's Hospital Reports. Without in the least professing to collate statistics, I will take from these volumes a few statements of fact which bear with much interest upon my subject. The records of cases at both these hospitals are, as is well known, admirably kept.

I will take first St. Thomas's Hospital. In the records for the year 1869 I can find no mention of croup, diphtheria, laryngotomy or tracheotomy. In 1870 one case of diphtheria is mentioned. It was in an adult, and recovered without an operation. In 1871 there was one case of diphtheria; in an adult, and fatal, without operation. On the surgical side there was one of croup in a child under five, fatal in a few hours after tracheotomy. In 1872 there was a single case of tracheotomy for croup in a young child. It was fatal. In 1873 two cases of diphtheria are recorded, and both ended fatally. In one the diagnosis was doubtful, and no operation was demanded. In the other, a child of nearly two had tracheotomy performed immediately on admission, and died a few hours afterwards. The post mortem showed "the larynx and trachea filled with false membrane." A third case of diphtheria originated in the hospital, and ended in death. In 1874 the medical registrar reports five cases of diphtheria, three of which had originated in the hospital (in nurses). These three were not severe, and all resulted in recovery. One case, which ended in death, is worthy of being quoted in full, since it conveys an important lesson as to the mode of development of the disease. It also discloses the fact that at that time insufficient attention was given to the removal of false membranes.

"A child, æt. 3, was admitted on May 10th, having had what was supposed to be a severe cold for three days before; she was seized on the day before

admission with sore throat and severe croupy cough; the respiration rapidly became embarrassed, and when admitted she was livid and apparently moribund. Tracheotomy was immediately performed, with great relief, and the patient slept well, and took food; but on the following day the respiration again became embarrassed, and death occurred about thirty hours after the operation. *Post mortem* :—Exudation was found in the upper part of the pharynx and the posterior nares, and the whole larynx and trachea were completely plugged by a quantity of exudation, forming a solid cast of the tube. The larger bronchi were also filled by exudation and the lungs partially collapsed.”

The surgical report for this same year (1874) records five cases of diphtheria, all fatal, and one of croup, also fatal. All six patients were under five years of age. In all, tracheotomy had been done on the day of admission.

In 1875 the medical report gives seven cases of diphtheria, all recovering, and two of croup, both fatal. The surgical report gives two of croup (probably the same two) and one of diphtheria, all submitted to tracheotomy and all fatal.

From 1875 I take a leap to 1883.\* In this year the medical report records 32 cases of diphtheria with 16 deaths, whilst the surgical report does not mention croup, diphtheria, or tracheotomy. It would appear that the faith of the physicians in the benefits of operation had sunk so low that, although the disease was prevalent and fatal in no less than 50 per cent., they found no cases in which it seemed worth while to invoke the surgeon's aid.†

I will now turn to the Reports of St. Bartholomew's for the years 1889 and 1890, during which diphtheria was prevalent in that institution.

In 1889 the medical report records a total of 78 cases of diphtheria, of which only 33 recovered and 45 died. The surgical report gives 44 tracheotomies “for diphtheria and croup,” 22 being males and 22 females, and 32 being under the age of five. Out of this number there were 12 recoveries and 32 deaths.‡

In 1890 the medical report gives 148 cases of diphtheria,

\* My only reason is to save space.

† It occurs to me as a possible fallacy that some tracheotomies may have been performed in the medical wards, but if so, they are not mentioned in the medical report.

‡ The medical report differs a little from the surgical, and states that in this year there were 47 tracheotomies with 10 recoveries.

with 91 recoveries and only 57 deaths. Thus the disease would appear to have been milder, or the treatment better, than in the preceding year. The surgical report gives 21 tracheotomies, with the splendid result of 18 recoveries and only three deaths. Surgery had here in all probability greatly helped the general statistics of the disease, and the result is the more satisfactory because all the patients were children and 17 of them under five years of age.

I visited the Hampstead Hospital for Fever cases at the invitation of my friend Dr. Gayton, its medical superintendent, in order to learn what I could as to their experience of diphtheria and croup, and especially as to the success of its treatment by tracheotomy. My visit was on April 28th, and Dr. Gayton and his assistant, Dr. Winter, were good enough to show me at least half a dozen children who were doing well after tracheotomy, and to give me much interesting information as to their recent experience. The hospital is well situated on a hill, and consists of many isolated, one-storied blocks, very roomy, well ventilated, and, it is needless to say, in excellent order. It was in the first instance designed as a smallpox hospital, but as smallpox is no longer admitted to any institution within the London district, it is now used exclusively for the other contagious fevers, and chiefly for scarlet fever, measles, and diphtheria. Although under parochial management, patients from all classes are admitted.

Dr. Gayton told me that the supply of diphtheria patients is tolerably constant, with some periods of temporary increase and reduction. He did not consider that they had recently had any epidemic of it or any remarkable local prevalence.

Many of the cases were, so far as he knew, isolated examples in the family, and quite without any traceable history of contagion. In many other cases, however, two or more children would be brought in from the same family, or there might be the history that brothers and sisters of the patient had suffered from sore throats, although not of sufficient severity to require treatment. "Do you make any distinction between croup and diphtheria?" I asked. "None whatever," was his reply; "it seems impossible to diagnose them." This avowal interested me much, fitting, as it does,

with opinions which I advocated long ago in a discussion at the Pathological Society. For me croup is catarrhal laryngitis, and diphtheria is catarrhal laryngitis propagated by contagion. They come under the general law that all catarrhal inflammations may become contagious. I was further told that the most practical classification of diphtheria cases (using that term as inclusive of all forms of pharyngo-laryngitis attended with membrane) was into those in which the disease had originated either from catching cold or from contagion, those in which it had followed scarlet fever, and those in which it had followed measles. Of these the latter class were, if tracheotomy became necessary, by much the least hopeful, whilst those in which no exanthem had preceded the disease ("simple diphtheria") were the most so. If tracheotomy were done in a patient who had had measles, the wound, I was assured, would almost invariably become unhealthy. This item of information again interested me very much, as fitting well with a former observation that measles is the usual parent of cancrum oris, and is of all the exanthemata the one most prone to initiate phagadenic or gangrenous processes. An unhealthy condition of the operation wound appeared to be Dr. Gayton's chief dread after tracheotomy, and the previous occurrence of either scarlet fever or measles was held to predispose to it.

As regards the general treatment of diphtheria, I was told that tracheotomy was resorted to in all cases in which death by asphyxia was threatened, but that in a considerable majority of the cases brought to the hospital it never came into consideration. The usual internal treatment was by the free administration of steel. Dr. Gayton has what he calls his "iron drink," upon which he places great reliance. It consists of the tincture of sesqui-chloride of iron liberally sweetened and largely diluted. Of this the little patient is allowed to drink freely whenever thirsty, and I was assured that it was not at all uncommon for a child of five or six years old to take in twenty-four hours from half an ounce to six drachms of the tincture. As a topical application the old-fashioned honey and borax is in much favour. Neither mercury nor antimony are ever prescribed. As regards

tracheotomy, Dr. Winter told me that their statistics began with last September. Previous to that date the mortality had been so high that they would prefer to leave the cases uncounted. Dr. Gayton confirmed this, and told me that he had been so much discouraged during several years that he was on the point of coming to the conclusion that it was safest to leave the patient to his chance without resorting to the operation. Last September (1891), however, without any obvious reformation in practice, there was a change for the better in the results obtained, and recently from half to two-thirds of the patients operated on had recovered. Almost the only definite point of change in treatment which Dr. Gayton could mention was the introduction of the bi-chloride spray for the wound. This had of late been most systematically attended to, and to this he was inclined to attach much importance.

The early and frequent changing of the tube was another point which had received recently more attention than formerly. Within twelve hours of the operation the tube is now invariably taken out and the trachea cleansed, and after this it is always removed once a day. I was assured that with a little management and with great gentleness patients could be induced to bear this quite quietly. An anæsthetic, chloroform, is invariably used at the time of the operation, but never for changing the tube. During the latter process the patient is placed with the shoulders on a pillow and the head thrown well backwards. As regards the removal of false membranes at the time of the operation, Dr. Gayton assured me that they had for long attended most scrupulously to it, and he did not think that their recent increase of success had any connection with increased care in that matter. As a detail in the performance of the operation, I was told that it was not usual to use the knife further than for the division of the skin and the fascia. This having been done, the operator, with two pair of forceps, would next tear through the cellular tissue between the muscles until the trachea was laid quite bare. By this precaution the division of veins and of small arteries was avoided, and the operation was often almost bloodless. After the operation

the patients are placed, as is usual, in a curtained cot with a steam kettle playing. They are treated in different wards under different nurses, and but little is usually done in the way of internal medication. The duty of frequently spraying the wound with the bi-chloride solution is strictly enjoined upon the nurse, who is held responsible should any unhealthy condition of it result.\*

The picture painted by the facts which I have adduced is one of fitful lights and deep shadows. At one moment it would appear that tracheotomy for croup and diphtheria is a measure almost without hope, and at another that it is a highly successful procedure. There is not the least reason to believe that the discrepancy is, to any appreciable extent, to be explained by reference to the varying nature of the disease. The difference clearly is in the attention to the details of the operation and the after treatment of the case. If this attention be sedulous, unremitting and according to rule, it is probable that under all conditions a fair average of recoveries may be expected. If, on the other hand, the operator be content merely to do the operation and leave the rest to nature, it is obvious that it might as well be omitted. Tracheotomy for croup remains, in fact, a house surgeon's operation. In other words, the operator should be the surgeon who will have care of the patient afterwards, and he should be resident. It is only under such conditions that the necessary zeal and assiduity can be expected. It is also emphatically one of those operations in the performance of which it is most desirable that all young surgeons should be trained. I therefore make appeal to the many intelligent and highly educated men now holding these appointments that they should no longer permit this operation to occupy the uncertain position which it at present does. Success is clearly possible, and it ought to be attained.

*(To be continued.)*

\* Dr. Gayton has since written to me stating that since September 28, 1891, till the present, 36 operations have been performed, with the result that 16 patients have left the hospital well—14 having died and six still remaining under treatment. The youngest of the patients operated upon was one year, and the eldest nine years.

## NOTES ON OPERATIVE SURGERY.

### No. XIII.—*On the Operative Treatment of Intussusception of the Bowels.*

It was my good fortune about eighteen years ago to perform a successful operation by laparotomy for intussusception. My case was, I believe, one of the first successes, and it naturally led to my taking great interest in the subject afterwards. It was a case in which the intussusception was a very unusual length, the inverted head of the cæcum projecting several inches at the anus. Since that time a certain number of successes by laparotomy have been recorded, and side by side with them a yet larger number in which the operation has failed to save the patient's life. In a not inconsiderable proportion of the latter, it was found impossible to effect the reduction of the incarcerated bowel.

I will place what I now have to say on the subject under a few definite heads.

Proposition I.—It is absurd to institute any comparison between treatment by insufflation or injection and that by laparotomy. The rule of practice ought to be invariably to try the former measures in the early stages. It is only when they have failed that laparotomy ought to be thought of. The two measures are not competitive, but the one is supplementary to the other. Statistical tables instituting a contrast as regards the relative success of the two measures are mere waste of labour.

Proposition II.—Whilst fully admitting that insufflation and injection treatment ought to be tried first, it is to be borne in mind that these measures are not without risk. They are to be practised with judgment and caution, and not perse-

vered in too long. In not a few instances when done too boldly, rupture of the bowel has resulted.

Proposition III.—It is probable that there is not much reason for preference for insufflation, or injection of air, over injection of water. If the latter is done, the patient's body should be in the inverted position, at any rate during part of the time. As regards the details of the process, I prefer to do it by hydrostatic pressure rather than by a syringe, believing that it is more easy to estimate the amount of distensile force which is used.

Proposition IV.—If the patient be an infant, say under two years of age, it will be well to be content with repeated attempts by injection. The results by laparotomy in infants have been so almost invariably fatal, that it is safer to trust to the other measures.

Proposition V.—If the patient be more than two years of age, and a patient attempt at treatment by injection have failed, a prompt resort to laparotomy is to be recommended. It is desirable that this should be done early before the serous surfaces have become adherent, or the reduction of the incarcerated portion had been made difficult by swelling.

Proposition VI.—In the performance of the operation the difficult part is the withdrawal of the incarcerated portion of bowel. It is very important to remember that this is often most easily accomplished not by traction of the upper end, but by pressure on the lower, or by the two at the same time.

Proposition VII.—The older the patient, the slower in all probability will be the progress of symptoms in intussusception, and the longer the period during which it is practicable to effect relief by operation. Thus in adults an intussusception case may be protracted over weeks and even over months. The conditions present even after a very long interval may still be such as to permit of a successful operation.

In formulating the above propositions I have made no reference to the question of diagnosis. It is usually easy. The tenesmus, the bloody mucus, and, above all, the discovery of a tumour by manipulation through the abdominal wall, render the diagnosis of intussusception in a majority of cases very definite. It must be admitted, however, that there



## PLATE XLVIII.

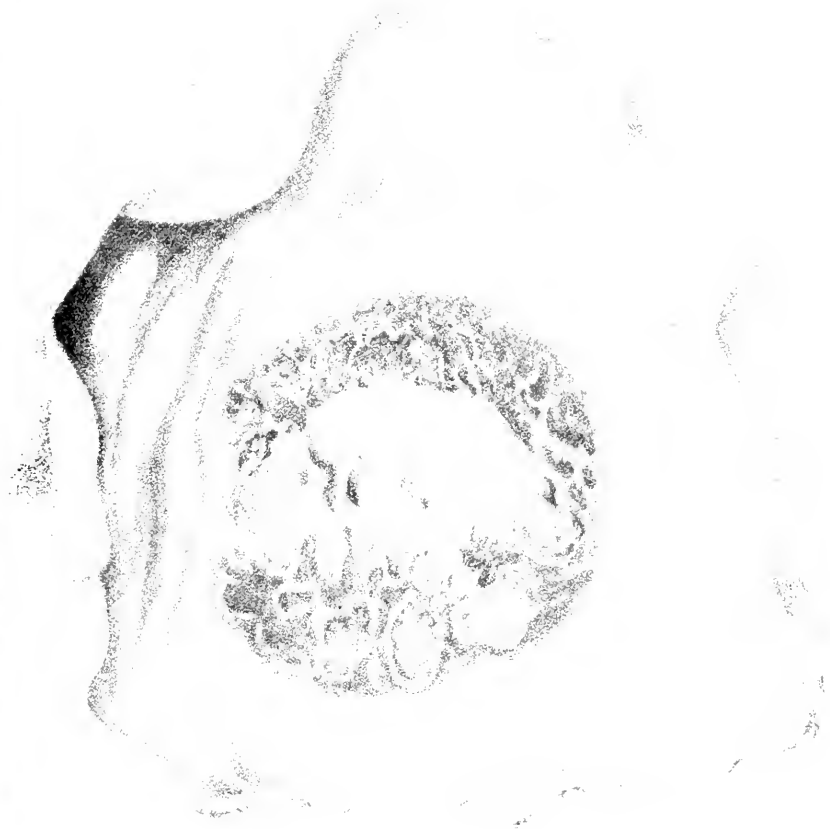
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### FIG. 1.—INTUSSUSCEPTION OF CÆCUM.

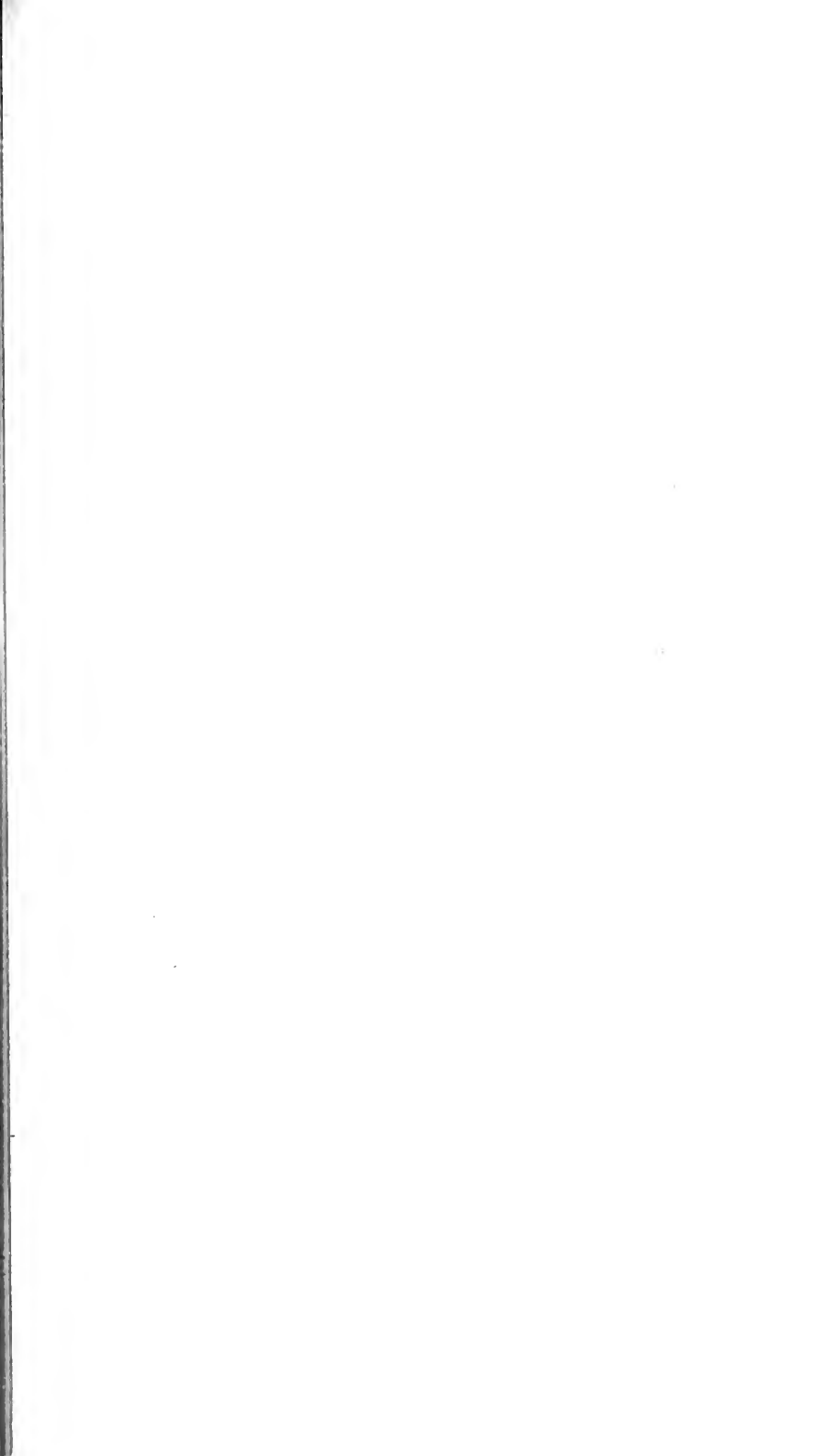
THE upper figure in this Plate shows the commencement of an intussusception of the ileum and cæcum into the colon. The latter has been laid open, and the florid mucous membrane of the involuted bowel is exposed. To the right is seen the ileum, and by its side the terminal portion of the appendix vermiformis, just about to be swallowed in the progress of the intussusception. The sketch was taken by Mr. Frederick Mackenzie, many years ago, from a child who died in the London Hospital after a severe burn. It may be taken as a good illustration of the earliest stage of the condition of which the next Plate shows the completion. Intussusceptions are very common at this part of the bowel.

### FIG. 2.—ULCERATION OF COLON FROM DISTENTION.

THE lower figure in this Plate shows commencing ulceration of the mucous membrane of an over-distended colon. At one spot perforation was just about to occur. The patient, an elderly woman, had died of exhaustion after nearly six weeks of almost complete obstruction of the bowels consequent on a malignant stricture. The diseased portion of the bowel was almost close to the stricture. The sketch was taken (many years ago) in order to exhibit the processes which in cases of long-continued obstruction precede perforating ulcer; and also the part most prone to be affected. The proper treatment of the case would have been a colotomy in the right loin. The portrait is a warning against too long delay of operative measures in similar cases.







## PLATE XLIX.

### INTUSSUSCEPTION PROJECTING AT THE ANUS.

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IN Plate XLVIII. is shown the commencement of an intussusception beginning with the ileo-cæcal valve. In the present one we have illustrated the final condition of this lesion, the ileum having travelled the whole length of the colon, and appeared at the anus. The ileo-cæcal valve itself still forms the apex of the involuted tract. The appendix cæci, completely swallowed, being of course in contact with the peritoneal surface, is concealed from view. This portrait is of especial interest as showing the exact condition of things which was present in the case upon which I operated, and which is referred to at p. 25. In that case, during the operation, when the involution was drawn out, the last structure to make its appearance was the appendix cæci. This drawing was from a child in which the disease, after the usual symptoms, had ended fatally. It will be seen that there are not the least indications of the usual tendency to gangrene, nor any evidences of tight strangulation. So far as appearances go, had an operation been performed, a reduction would probably have been easy.

The sketch represents the orifice of the anus, and the structure turned to the left is the urinary bladder. At the opposite end a probe has been passed into the intussusception, by the side of the contained gut.

The original drawing from which this Plate is copied was given me by Professor Gairdner, of Glasgow. It is a very valuable one, and I do not know of the existence of any other.



Wm. Yeoman, del.



are cases in which it is not so easy. I would venture to urge that in all cases of abdominal obstruction which present any symptoms similar to those of intussusception, and in which the injection treatment under an anæsthetic has failed after a fair trial, that the abdomen ought to be opened.

In the treatment of intestinal obstruction in general, it is a most important clinical rule that the first measure should be to put the patient under the influence of an anæsthetic. This should be done at the earliest possible period in the case. It has the double object of facilitating diagnosis and permitting those measures of treatment which are comprised under the term "abdominal taxis." Under this term I include systematic manipulation, inversion of the patient's body, vigorous shaking of the body in the inverted position, and the administration of enemata, also in the inverted position. By these measures carefully carried out in an early stage I believe that in a majority of cases of mechanical obstruction of the bowels success will be obtained, and if it be not, an operative procedure will probably be necessary. This procedure must either be a colotomy or a laparotomy. The choice will depend upon the diagnosis which seems most probable, as to the position and character of the obstruction. If the case be one of intussusception, it will be very rarely indeed that there can be any doubt as to the diagnosis after an examination in this manner.

#### No. XIV.—*Laparotomy for Impacted Gall-stone.*

I find recorded in the *Lancet* for May 21st, by Dr. Brockatt of Great Malvern, a case of much value in reference to the symptoms and treatment of gall-stone plugging of the intestine. The case so strongly supports the opinions which I have expressed on this subject that I cannot resist the temptation to reproduce it, and to state it in a schedule on the "space for time method." In this form it may easily and profitably be compared with the case given in Vol. III., p. 9. The two are very closely similar. I have insisted strongly that in these cases there is often no history of pain during the escape of the stone through the common duct, and the

symptoms often only begin when the intestine is plugged. The frequency with which the symptom of jaundice is wholly absent has also been clearly brought out. These points are well exemplified in Dr. Brockatt's case, for both pain and jaundice appear to have been quite absent. Nor, although the stone was very large, was there much evidence of its having previously caused trouble.

I have Dr. Brockatt's permission to republish his case, and he has also been good enough to give me the additional information that the stone weighed two ounces. It was clearly a very large one. It is now, I believe, in the Museum of St. Thomas's Hospital.

*A Case of Gall-stone Plugging. Symptoms of a bilious attack. No pain. Much vomiting. Operation on ninth day of illness, and a large gall-stone removed from jejunum. Death five days later from Peritonitis. Dr. Murphy and Dr. Brockatt. (See the Lancet for May 21st, p. 1130.)*

DATE.	DAY OF ILLNESS.	DETAILS.
Dec. 20	3	First seen by Dr. Murphy on the third day of a "bilious attack," which had been attended by vomiting. <i>No pain.</i> Three days' constipation. Normal temperature. Anxious expression. Great thirst.
„ 21	4	No note.
„ 22	5	Slight action of the bowels; less vomiting. Patient feeling better. Enemata followed by three large stools.
„ 23	6	Patient ate some chicken. The vomiting returned, and large quantities of bile were ejected.
„ 24	7	Much in the same condition. <i>No pain.</i>
„ 25	8	Vomiting still persisted, and the matters ejected "very offensive." Abdomen much distended. <i>No pain.</i> Tongue dry and brown. Pulse 120.
„ 26	9	OPERATION (under anæsthetic, a hard, freely moveable mass easily felt). Abdomen opened and a large gall-stone, which plugged the jejunum, removed.
„ 27	10	Doing well. Temperature normal; pulse 96. <i>No pain</i> ; no vomiting.
„ 28	11	Doing well.
„ 29	12	Very weak.
„ 30	13	Still more weak.
„ 31	14	Died from exhaustion and peritonitis (sixth day after operation).

*Post mortem.*—The autopsy showed slight but definite evidences of peritonitis. The incision in the intestine was well united. The stone was pear-shaped and two inches long, and five and a half in greatest circumference.

No. XV.—*On difficulties in the Diagnosis of Tumours under the Sterno-cleido Mastoid Muscle.*

I quote the following, with feelings of much sympathy, from a Japanese medical journal :—

“ Dr. J. Kimura brought before the Society a woman of 23 years old, who began to have a swelling in her neck, which at present occupies the side of the neck, from the mastoid process to the point two inches above the clavicle. Dr. Oka said it will be a cystic tumour, Dr. Sewaki believed it a tubercular lymphatic glands, Dr. Sasaki lymphosarcoma, Dr. S. Kimura a cystic tumour, Dr. S. Suzuki an abscess originating from tubercle in lymphatic glands, and President Takaki a cold abscess.”

There is perhaps no class of tumours which present greater difficulties in diagnosis than those which occur in the neck. Witness the very interesting case recently recorded by Mr. Croft, in which a tumour, supposed to be an abscess, was found to communicate with a vein, and ligature of both artery and vein were required. I have myself recently had under observation two cases in which fusiform swellings, possibly gummata, occurred in front of the carotid and partially surrounded it, simulating aneurism. In one of them I could not for some weeks feel quite sure that it was not an aneurism. We may remember that Liston, in the case of a young boy, opened what he supposed an abscess, and had to tie the carotid for aneurism. The precise nature of this case was never satisfactorily established.

The case which puzzled the Medical Society of Tokyo does not, however, appear to have been one in which the blood-vessels were concerned. Under the upper third of the sterno-cleido mastoid we may have the peculiar potato-like tumour (a lympho-sarcoma), to which I have repeatedly asked attention. We may have also a very peculiar cystic tumour, which bulges both in front of and behind the muscle. This cystic tumour will often in adult age inflame and suppurate. It is almost impossible to dissect it out, and exceedingly difficult to get it to cease secreting after it has been opened. Next, it is not very infrequent for a gland in this position to suppurate

slowly and constitute a very large, thin-walled cavity, exactly like the cyst just described, and wholly without inflammation. The exploring trocar is the only means by which to decide whether such a tumour contains this glairy pus or transparent cyst-fluid.

No. XVI.—*Note on the History of Operations for Varicose Veins.*

In the beginning of the present century the ligature of veins for the cure of ulcers was not uncommon. Sir Everard Home recommended it, and spoke lightly of its risks. That the latter were not inconsiderable, however, is made quite clear by the medical literature of the period. Phlebitis and pyæmia, followed by death, appear to have occurred every now and then. Mr. Oldknow of Nottingham, writing in the *Edinburgh Medical Journal*, states that he had been taught to consider the operation a very trifling one, but he records a case in which his patient, a healthy young man of twenty-three, died on the twenty-second day, with symptoms which, at the present time, we should certainly regard as those of pyæmia. The saphena vein just below the knee had been tied in an open incision. The use of antiseptic applications, and the great care as to cleanliness, &c., have together in the present day all but absolutely deprived these operations of danger. I can well remember a time when they were looked upon with considerable disfavour in most of the London hospitals, and although no great number of operations were done, I yet also well remember a few instances of disastrous consequences.

No. XVII.—*On Causes of Death in Midwifery.*

The statistics of midwifery, and the causes of death after childbirth, are not without their interest for the operating surgeon. To a considerable extent the same kind of risks are encountered after delivery as after a large operation wound, and the same kind of precautions are needed.

My friend Dr. Aveling, one of the highest authorities on these matters, assures me that in spite of all modern improvements in practice, the ratio of mortality after parturition in

English practice has not been reduced lower than one in two hundred. The chief triumphs of recent days have occurred in the reduction of mortality in Lying-in Institutions. In private practice it is probable that for long the ratio has not been higher, and that no great change has resulted recently. It would appear, to judge from the statistics of individual practitioners, that it is very difficult even under the most favourable circumstances to beat the record.

I have before me a number of the *New Zealand Medical Journal* which contains the statistics of 2,590 cases occurring in the practice of one surgeon (Dr. Sealy). They give a mortality of 1 in 259, being just a little better than the average. It will be seen from the following list of causes of death that something of the nature of puerperal fever claimed about half.

- 1 from scarlet fever, 11 days after confinement.
- 1 from acute pericarditis, 2 days after delivery.
- 1 from uterine inflammation and fever, 18 days after.
- 1 from post partum hæmorrhage, half-hour after delivery.
- 1 from the effects of hæmorrhage, 2 days after delivery.
- 2 from puerperal fever, each 9 days after delivery.
- 2 from typhoid fever, 12 and 10 days after respectively.
- 1 from bronchitis, 3 days after. (There was no particular temperature, and nothing septic in this case.)

## DISEASES OF THE NERVOUS SYSTEM.

No. XXXVI.—*Symmetrical Mydriasis with Cycloplegia (Ophthalmoplegia interna)*—*Four years' interval between the attacks in the two eyes, and of a sort of seizure in connection with each.*

The peculiarity of the case I am about to narrate is that the patient has sustained loss of accommodation in both eyes, together with dilatation of the pupil, but without other symptoms of defect of third-nerve muscles. Nor has he any of the usual indications of commencing tabes. Mr. W—, a rather spare, very healthy-looking man, brought me a letter from a professional friend, three sentences of which thus summed up his case : “He is a rheumatic subject, and has had ague and syphilis. Some years ago his left pupil became dilated, with some loss of vision and focussing power. Now the right eye has followed suit.” In pursuing the hints thus given, some very interesting details were elicited. I did not succeed, however, in arriving at any definite diagnosis as to whether this very exceptional condition ought to be attributed to syphilis or to ague. The patient’s condition was—pupils dilated to the size of No. 11, and fixed ; unable to read excepting with +10, and being somewhat hypermetropic, needing +40 for distant vision. The fundus of each eye was normal, and he had no iritic adhesions. Excepting these conditions in his eyes he had no other symptoms of ill-health, and those which he described in the past chiefly had reference to the ague from which he had suffered. He had no headache ; he could walk quite well with his eyes shut, and he had had no bladder symptoms nor any definite ataxic pains. If he had ever had syphilis, it was five and twenty

years ago, and nothing had since occurred to remind him of it. He had suffered severely from ague when a young man living in the marshes near Gravesend. Through life ever since he had been liable to feverishness and aching pains whenever exposed to cold, and he had taken much quinine. The greater part of his life had been spent in districts not wholly exempt from malarious influences. He had been married for twenty years, had two healthy daughters, and had lost no children. His own expression as regards his eyes were: "Four years ago the pupil of my left eye enlarged, and now the other has gone too." He asserted that on each occasion the dilatation of the left pupil, and accompanying defect of sight, were preceded by a sort of seizure, which he described with much detail. It appeared, however, on carefully questioning him, that the failure of the eyesight was noticed a day or two before the first so-called "seizure," and that on the second it did not follow for a day or two afterwards. The fact remained, however, that of these "seizures" he had had but two, that the interval between them had been four years, and that one of the eyes had been affected after each. He described his last seizure as follows: "I had gone down to Brighton quite well, but found myself tired with the journey, and was feverish and had aching joints, as if ague was threatened. I took an opening pill; was very feverish through the night, and the next day had diarrhœa and felt languid. On going upstairs to bed I felt faint, and had a dreadful buzzing in my right ear, as if a champagne-bottle had been uncorked close to it. My wife helped me to a chair. I did not faint or lose consciousness; and in two or three minutes the sensations in my head died away, and I broke out into a profuse perspiration. The next day I was better, but on the following morning I found that I could not see well, and that the pupil of my eye was enlarged, as that of my left had been for four years." Respecting his first attack he could not give so much detail, but he remembered that the "terrific buzzing" in his ear had lasted much longer than on the second occasion, and that it had been followed by "a dreadful sweat." It also had occurred just as he was going to bed, and after he had been, for several days, not feeling well. As far as he could remember, the left

eye had failed two or three days before the attack. No improvement whatever had followed from any of the remedies which he had used, either after the first or the second attack. The pupil had remained on each occasion dilated and motionless, and the defect of sight now amounted to almost complete loss of accommodation. On neither occasion was he actually taking quinine at the time of "the seizure."

There is but little else that seems worthy of mention in Mr. W——'s case. He had never had squint or definite double vision. His upper eyelids did not droop in the least, and I could not detect any imperfection in any of the external third-nerve muscles. His knee-jump was very excessive. It occurred with extreme rapidity, and unless he made voluntary effort to prevent it, was attended by movement of the arm on the same side. Constipation had been a very troublesome condition through the whole of his life. He had sometimes experienced shooting pains in the knees, which had been called rheumatic. It will be seen that the condition of the pupils present in this case is, as regards size, the converse of what is usual in ataxy. We do, however, occasionally in this malady see the pupils dilated instead of contracted.\*

No. XXXVII.—*Burning pain in the limbs of one side as a symptom of Brain Disease—Liability to temporary Aphasia—Epilepsy, Melancholia, Mania, and Death.*

Dr. Lyle, of Dunmow, brought to me a married man, aged 37, whose chief complaint was of a burning sensation down the outer side of both upper and lower limbs on the right side. He said that the burning was such that he could scarcely bear it. He had, however, other and much more definite symptoms. His speech was slow, and his thought-processes were clearly very dull and imperfect. He had no knee-jump whatever, and his pupils were rather large and sluggish. There was a history that three months ago, whilst

\* Whilst this sheet has been in the printer's hands a somewhat similar case has come under my observation.

driving in his dog-cart, he had had a fit and fallen out. After the fit he was able to get up again and catch his horse ; but it was followed for a time by aphasia. His wife stated that now and then during the last twelve years—that is, the whole of their married life—he had been at times unable to speak. On the whole, however, he had enjoyed good health, and had never needed medical advice. There was a history that a few years before his marriage he had suffered from syphilis. I examined his optic discs and found no changes. He could walk fairly well, and could maintain conversation, although, as stated, it was slow and without animation. It was on October 7, 1890, that I first saw this patient ; and he was brought to me for a second time on December 4th. In the interval he had had several epileptiform attacks, and his memory had very decidedly failed. He had become dull and melancholy.

Two or three months after his last visit to me the patient was seized with mania, and had to be removed to a lunatic asylum. His raving was violent, and continued, I was informed, up to the time of his death, which occurred about three weeks after his confinement.

In the absence of post-mortem evidence, it may be conjectured that the lesions were cortical, and that the disease was a form of general paralysis of the insane. I have thought it worthy of record on account of the peculiar burning pain in the right limbs which proved to be so ominous as a symptom.

No. XXXVIII.—*A peculiar form of aggressive Hemiplegia of four years' duration, and characterized by numbness and subjective coldness rather than real anæsthesia—Paralysis of common extensor of toes.*

Mr. J——, 63, a healthy-looking man. Four years ago, whilst sitting at the fireside, he suddenly felt a numbness in the left arm. "It went up the arm, down the side, and to the leg." He was worse next morning, and stayed in bed an hour or two ; but when he got up he could stand. At first there was only numbness, but gradually loss of power came

on. He was never disabled from walking, and never had retention of urine. Throughout, sensation was affected in excess of motion. His face was never paralyzed, but he says that his ear feels numb. He can make mouths. He complains that he cannot touch cold things with his left hand, as it sends a pain up his side and into his leg. He has a sensation of cold in the left side of face; when he puts it on the pillow it feels painfully cold. He says that he cannot use his toes except the big one. Knee-jump excessive on left side and good on right. There is nothing whatever to be observed in the hand or forearm. Their nutrition seems perfect, and he uses all their muscles well. He complains, however, that use of the hand makes it ache, and that it feels numb. There is no difference in special muscles.

He considers that the conditions described have been gradually increasing ever since he was first taken, four years ago.

There is no real anæsthesia, but a general sensation of numbness and coldness. No wasting or contraction of muscles, but he cannot use them easily, and they ache after use. Sometimes he has difficulty in straightening his knee, and the muscles feel stiff. He uses the long extensor of the great toe well, but cannot use the extensor of the other toes more than a very little. The toes of both feet are in the hammer position, the great toe being excepted. The inability to use the extensor of his toes has been present ever since he was taken. Sight and hearing good.

I narrate this case, as the preceding one, on account of the singular character of the principal symptoms which attended it.

No. XXXIX.—*Recovery after fracture of base of skull, with permanent paralysis of the third and fourth nerves on the right side.*

On February 15, 1884, I saw at the Poplar Hospital, with Dr. Brownfield, a patient of his who had recovered after probable fracture of the base of the skull. The chief feature of interest in the case was that it seemed likely that the trunks of the third and fourth nerves had been torn across.

The man, at the time of my visit six weeks afterwards, had still the symptoms of complete paralysis of these nerves, and of none others. The eyeball diverged, and could not be moved either inwards, upwards, or downwards; nor when told to look upwards or downwards was there the slightest rotation of the eyeball on its axis. The pupil was widely dilated, and accommodation was quite lost. We did not get his vision very accurately, but I ascertained that he could read large print with a convex glass, and I was told that the ophthalmoscope revealed no changes in the disc. The eyelid drooped so as to entirely cover the eye.

The injuries in this case had been caused by the man falling into the hold of a vessel. He had remained where he fell for twelve hours before he was found, and was then taken up insensible. There was slight bleeding from the right ear, and much bruising upon several parts. When I saw him, he had quite recovered, and enjoyed the full use of his faculties. He complained that his right arm was a little numb and weak, but there was nothing very definite. He was not deaf in the right ear, and there was no paralysis of either portio dura. His lower jaw had been fractured. I was told that he had been delirious, pulling his bandages off, &c., during the first fortnight. There had never been any serous discharge from the ear, and probably the bleeding which had occurred had been only from the external parts.

No. XL.—*General muscular debility in a young child—Rapid decay of temporary teeth—Syphilis suspected—History of profuse and almost fatal hæmorrhage from the vagina in very early infancy—Obstinate constipation.*

Mr. C—, of T—, sent me a case of much interest and of great difficulty as regards diagnosis (May 10, 1886). The child, a girl of two and a half years, could neither walk nor talk, and was only just beginning to crawl. All her teeth were cut, and all were fast rotting away level with the gums. The child was fairly well grown, of good complexion, and although her forehead was prominent and a little peculiar,

the skull showed no bosses. There was no history of syphilitic symptoms in infancy. She was the first which had lived. Two previous conceptions had ended, one in a dead child after a difficult labour, the other in a premature birth at six months. The facts just mentioned, coupled with the father's confession to having had syphilis five years or more before marriage, had led to the prescription of specifics for the mother. They were taken with some irregularity during the whole of the third pregnancy. Since the birth of this child, another, a boy, had been born who was now aged six months and in excellent health.

I saw both parents, and they appeared to be exceedingly well. The father, who was quite candid, had not had any reminders since his first treatment. We had to account for remarkably slow development, with soft, flabby muscles, especially in the lower extremities, coincident with rapid decay of all the milk teeth.

I was inclined to attribute the latter to the mercury which the child's mother had taken through her pregnancy. Two facts as to the child's infancy have yet to be stated. When two days old, she bled from the vagina (or bowel) continually for forty-eight hours, and became so weak that she was unconscious, and it was not thought possible that she could live. Her mother holds that she never got over this, and perhaps she is right. The next fact is that the child through her whole infancy was constipated to an extraordinary degree. Was this a cerebral symptom? Did it denote defect in nervous system, and especially in vaso-motor?

The child reminded me of certain cases of infantile cerebral paralysis, but there was no paralysis, only flabbiness and debility. This state was greater in the lower extremities than the upper ones. She could hold things in her hands fairly well. No convulsions had ever occurred in infancy. She was very good-tempered. I examined one eye with the ophthalmoscope, and found no peculiarities excepting that the retinal vessels were small and that there was a large crescent of pigment on the edge of disc.

Does extreme constipation in infants usually go with defect of the cerebro-spinal system?

I advised that there was no proof of syphilis, and perhaps not much probability of it. The case to be treated on general principles and without specifics.

No. XLI.—*The beginnings, or early symptoms,  
of Tabes.*

A case of great interest, as illustrating what was, I have no doubt, the early stage of locomotor ataxy, came under my care in March, 1889 (Mr. L——). The patient, a very healthy-looking gentleman of fifty-one, had had what he called “bladder troubles.” They had begun by a too frequent desire to micturate, which was soon followed by frequent escape of urine both in the day and night. The desire, although frequent, had never been urgent, and he would frequently have incontinence without having experienced any desire whatever. A urinary specialist whom he consulted proved to him by the use of a catheter that he had habitually a large quantity of residual urine, and advised the employment of an instrument three times a day. This plan had been carried out for about fourteen months before I saw him. On first rising from bed in the morning, he could, with a little patience, succeed in nearly emptying his bladder. In the afternoon he again used his catheter, and again on going to bed. In this manner he managed to escape any discomfort from incontinence. He had never had any characteristic tabetic pains in the legs. His knee-jump was still moderately good, and he could walk, he said, five or six miles without fatigue. In spite, however, of the absence of the pains, &c., the following symptoms seemed to me to justify the diagnosis of impending tabes. He complained very much of a sense of fulness and weight in his abdomen, as if it were constricted. He had for a time, six months ago, been what he called “groggy on his legs,” and at this time one of his pupils, the left, had been widely dilated. The pupil had recovered, and both were now of normal size, and, though very sluggish, were capable of a certain degree of contraction and dilatation. He said that he frequently experienced slight muscular twitchings in his legs, what he called “live blood.”

As regards the possible causes of tabes in this case, the patient admitted having had syphilis five and twenty years ago. For it he took mercury, and apparently got quite well, having never since had any reminders. He had been married for nearly twenty years, and had a family of healthy children. He had worked very hard in professional life in London, and as bearing on the question of defective tone as a cause of his symptoms, he had noticed that his power over his bladder always increased during a stay at the seaside. He had also experienced great benefit from nux vomica and valerianate of zinc, and he thought that the iodides had always made him worse. He had already consulted several nerve specialists, two of whom had told him that syphilis had nothing whatever to do with his symptoms, while another had expressed doubt. My advice to him was to abstain entirely from sexual intercourse, to avoid the iodides, and to take small doses of mercury combination with nux vomica.

No. XLII.—*Tabes characterized by very severe pains during twenty-five years—Charcot's Disease of one Knee-joint.*

An important example of tabes denoted almost solely through a long series of years by pains in the lower limbs, but attended ultimately by a disorganized knee-joint, was brought under my notice by Dr. S——. Our patient was an elderly gentleman (Captain R—— H——), aged 68; he had suffered from syphilis in a mild form about forty years ago, and for nearly thirty he had been liable to most severe shooting pains in his limbs. He had married five or six years after his syphilis, and his pains were at their worst about seven years after his marriage. From this time, and for ten years onwards, he was never free for more than a week or two at a time. Both his wife and he agreed in describing the pains as having been of terrible severity; they used to keep him awake a whole night. During the last ten years these pains had been much mitigated, though by no means absent. He had suffered, however, a great deal from want of tone in the bladder, and inability to empty it. He

had often had cystitis, and had been compelled to use a catheter a good deal. Until quite recently he had been able to walk well, and had experienced no failure in his general health. In this respect his case is very similar to that of Dr. —, of H—, who has for thirty years been liable to great suffering from tabetic pains, but who has not developed any other symptoms. Captain H— was brought to me on account of the condition of his right knee-joint. It was full of fluid, the synovial pouch passing up the anterior third of his femur. The tibia was loose, and there were evidences of bony outgrowths, and there are irregular thickenings both in it and the femur. He had no material pain in the joint unless he took exercise. The joint had been aspirated a few weeks before I saw him, and sixteen ounces of synovia removed. It will be observed that it had been a sub-acute affection, for the joint had been perfectly well until within about two or three months of my seeing him. He had then had an attack of general swelling of the limb, supposed to be due to venous thrombosis. In confirmation of the diagnosis of tabes, it may be added that his pupils were motionless, his knee-jump quite absent, and that he could not walk with the eyes shut.

## DISEASES OF THE SKIN.

### No. LVI.—*Some general considerations as to Acne.*

If we would correctly interpret the phenomena of acne, we must begin by calling to mind the fact that in the human subject a general but irregular suppression of hair-growth has taken place. With the exception of certain regions, man has ceased to be a hair-protected animal. The sebaceous glands, which are originally adjuncts of the hair follicles, have at the same time undergone great modification. On most parts of the skin they have no doubt been much reduced in number and in size. In some they have become liable to occlusion of their orifices, and in many they have ceased to open into hair follicles and have their orifices on the surface of the skin. Although growth of hair has in many parts entirely ceased to occur, yet partially developed hair follicles still exist and receive into their necks the ducts of the sebaceous glands. On certain parts of the body in the human subject no tendency to suppression of hair has as yet been observed; these are the scalp, the armpits, and the genitals. On others, as for instance the face and certain parts of the trunk, the growth of hair varies with the race and the sex. The suppression of hair in general has been far less complete in the male than in the female sex, and whilst hairy men are common, it is very unusual to see any differences in different women as regards the tendency to grow hair in unusual positions. As a general law the suppression of the sebaceous system is in ratio with that of the hairs, though far less complete. In women the sebaceous glands are fewer in number, smaller in size, and less active in function than in men. The limits of variation are also much more restricted in these respects in women than in men.

From a consideration of the facts above recapitulated we

may obtain valuable assistance in the consideration of such diseases as those known respectively as Acne, Sycosis and Lichen. If for classification purposes we give these names anatomico-pathological definitions, they would probably be much as follows. When the orifice of a hair-follicle having no hair becomes the seat of chronic thickening, we name the little firm papule thus produced "Lichen." When a hair-follicle, containing a hair, inflames and suppuration ensues, and the lining membrane is loosened so that it may be pulled away with the hair, we name the disease "Sycosis." When a sebaceous gland (formerly the appanage of a hair now suppressed) becomes, first distended with its own secretion and then inflamed, we name the condition "Acne." It will be obvious, however, that the conditions described can be appreciated, as distinct, only when they are well marked, and that there must be many instances in which they are mixed. For working purposes, however, these definitions will be found sufficiently accurate. Sycosis can occur only in parts where hairs grow, for it is disease of the follicles. Acne, on the contrary, can occur only where sebaceous glands are met with which have no hairs in connection with them. If hairs were present their follicles would be involved, and it would become sycosis at once. Lichen is a less well-marked affection than the two others, and differs from them rather in the type of the inflammatory action than in the structure affected. If a lichen papule should tend to suppurate, it would probably be called either sycosis or acne. In many instances lichen papules are indeed a stage of acne, whilst in others they are a part of eczema. In any case we name the disease as a whole, not so much from the peculiarities of individual elements as from the general character of the whole. The terms lichen-eczema and lichen-acne are both of them perfectly well founded on real conditions and tendencies, and are very useful in practice.

If we now confine our attention to acne, certain *a priori* propositions appear to be justified by the facts which have been cited.

Inasmuch as the endowments in different individuals in respect to number and size of sebaceous glands vary very

much, so ought we to expect the tendency to acne to vary. Since, as a rule, the sebaceous system is less developed in women, we may expect acne to be more common and more severe in males. This expectation is, however, to some extent controlled by another consideration which tells in the other direction. The development of hair appears to give to the sebaceous glands a healthy stimulus and to prevent their passing into morbid states. Thus men in whom hair is very abundant on the face rarely suffer from acne. Lads who at and after puberty were liable to acne often lose it as the facial hair develops. Men who have much hair on their backs rarely suffer from acne in that region. In women, however, the whole of the facial hair is suppressed, so that they lose its beneficial influence. Thus, although in them the glands are neither so large nor so numerous as in men, yet they are prone to suffer frequently from acne. The acne of girls, however, is almost always confined to the face, and it is very rarely so severe as it often is in young men. Backs covered all over with comedones and acne-furuncles which we so often see in young men are fortunately seldom or never witnessed in the opposite sex.

#### No. LVII.—*Cacatrophia Folliculorum*.

Under the name *cacatrophia folliculorum*, the late Dr. Tilbury Fox described and endeavoured to specialize certain conditions allied in part to lichen and in part to acne, in which the skin becomes rough owing to prominence of the orifices of the hair follicles. The parts usually affected are the outer surfaces of the upper arms, and the patients who present this condition are almost always young women. Every one will be familiar with the condition named who has paid attention to the state of the skin on the parts mentioned in young women of a rather feeble circulation. It is very common indeed in slight degrees, and is but seldom allowed to count as a disease. It is rather a peculiarity of the skin, and it usually persists during many years, but, I think, disappears gradually when adult-life is established. The often-quoted comparison of the skin to "a nutmeg-grater" is very appropriate for the more marked cases, and the special locality

affected almost in itself gives the diagnosis; for it is never seen on the flexures, and although it may be present in other parts it is invariably best marked on the backs of the arms. Dr. Tilbury Fox's description seemed to me to be clinically correct, and although I do not find that it has received much recognition by subsequent writers on skin diseases, I yet think that his name is a convenient one. It should be observed—and it is surely a decided advantage—that it is a name for a pathological condition and not for a special disease, or, as the phrase is, a morbid entity. A less than perfect state of nutrition of the hair follicles persisting for a long time, but not attended by any acute inflammatory disturbance, is of frequent occurrence, and may become an element in more than one of the affections of the skin which have received special names. It depends probably quite as much on the original endowments of the skin, its congenital peculiarities, as upon any influence which has been brought to bear upon the state of health of the individual; and, if we admit this, it follows that it is likely to vary with the special conditions as regards the structure of the skin of each individual patient.

I have made the above remarks as introductory to the description of a group of very peculiar cases in which very minute papules are produced on the face and other parts in connection with follicles. The peculiarity of the cases consists chiefly in the extreme minuteness of the changes. It may be noted also that they are always symmetrical, and that they begin in very early childhood. Although I have no doubt that I have seen this condition in a good many patients, I have only taken special note of its peculiarities in two or three: of these the following is one of the best examples: Lady E—— H—— brought to me her daughter (who was a very fair-complexioned and florid girl, with a thin, transparent skin) on account of an eruption on her face. The eruption involved the middle of the forehead just over the root of the nose, both eyebrows, and the parts of the cheeks which in a man would be occupied by the whiskers. It was also present to a very slight extent on the nose. It was most conspicuous on the forehead, and here it consisted of

little hard, dry papules, none of them bigger than pins' heads, and many not nearly so large. They were scattered thickly over the skin of the part named, the tendency to them ceasing gradually on the forehead. The whole of each eyebrow was involved in a similar condition, though the changes were yet more minute, and the same is to be said of the cheek-regions in front of the ear. A slight degree of congestive redness of the surface attended the disease on all parts, but nowhere was there the least tendency to the formation of pustules or acne spots. The disease might have been named with equal propriety a lichen or a minute form of acne. As disconnecting it with the causes of the common types of the latter disease, and as distinctly associating it with Devergie's lichen pilaris, it must be added that the condition had been noted in very early childhood, and that the patient was as yet only thirteen years of age. On the arms the deltoid regions were covered with similar but larger spots, and there were some also down the backs of the arms. I must add that there was a very slight tendency to ophthalmia tarsi, that is, there was a little secretion adhering to the roots of the eyelashes, but neither on the eyebrows or eyelids had any of the hairs been destroyed.

No. LVIII.—*Racial peculiarities as regards Acne.*

It would be of interest to know any peculiarities which acne may assume in reference to race, and I think it worth recording that the very worst case of acne on the trunk which I ever saw was in a Japanese. This gentleman, who appeared to be in good health and was aged twenty-four, showed me a few insignificant acne spots scattered over his face, and more especially on his chin. There were not more than half-a-dozen which had become pustular. On making him strip, however, I found his chest and back covered with scars, and large acne pustules. Many of the latter had suppurated and needed to be opened. There were very few comedones, whereas I never saw the skin of an Englishman affected with acne to anything like the same extent without there being also abundant comedones. The severity with which the chest suffered

was remarkable, the acne passing down nearly to the navel. On the back it passed down upon the loins and even to the hips; and on the arms, after covering the deltoids, it extended in a more sparing manner to the elbows.

No. LIX.—*An Erythematous and Thrombotic eruption occurring in the limbs of a healthy infant—Spontaneous recovery.*

The following is an extract from a clinical lecture which I gave some years ago at the London Hospital, with the patient before my class. It describes an acute erythematous eruption, which occurred, without obvious cause, in an infant, and which disappeared spontaneously. I am not now better able to name the malady than I was at the time, and I place it on record in the hope that others may be found to go with it, by the help of which we may eventually be able to recognize its real nature.

That the eruption was allied to urticaria is, of course, an obvious suggestion. The limitation of the eruption to the limbs, the almost complete absence of irritation, and the thrombotic developments are, however, features in which it definitely differed from that malady. That it was caused by some unrecognized error in diet on the part of the mother is not improbable.

Extract from Lecture :—

“The infant before us is, as you see, practically well, and she has recovered from an eruption which looked very alarming at the time of her admission. Yet we have not adopted any active treatment, nor indeed have I been able to give the disease any definite name. The child was sent to me by Dr. Edwards, of Keston, and its mother, who brought it, appeared to be in excellent health. She told us that she had two older children at home, neither of whom had suffered from any eruption. The infant herself, in spite of the state of the skin, appeared to ail little or nothing. She is eight months old, and has cut several teeth.

“Let me now describe the eruption. It affected the face, and the four extremities, entirely exempting the trunk; but

covering those parts of the hips and shoulders which belong to their respective limbs.

"It was symmetrical. It consisted of large, irregular, map-like areas of erythema, or of reddened skin, most of them abruptly margined. These underwent very rapid changes, being at first simply erythematous, then becoming livid, and subsequently brown. Only during the very earliest stage was it possible to make the colour disappear by pressure. Subsequently, it was clear that thrombosis and blood-staining of the adjacent parts were a chief part of the process. The last stage was a brown mark, often very irregular in shape, and so deeply tinted that the patches looked just like superficial moles.

"Fresh patches appeared day by day, and there were always some in various stages present at the same time. The eruption had been out for about ten days when the child was admitted; and you will remember that I discussed at the time various hypotheses as to its nature and cause.

"For various reasons, I put aside the *prima facie* suggestion that it was due to inherited syphilis. The eruption had come out too suddenly and too severely, and passed through its stages too rapidly. There was, besides, nothing in the child's appearance, nor in the family history, to support, in the least, such a supposition. My next thought was, that it was probably one of the multiform eruptions which occur (in connection with idiosyncrasy) from the administration of the iodides and bromides. I should still think this suggestion probable, were it not that the mother assures me that no medicine had been given."

### No. LX.—*An Eruption caused by Vanilla.*

Dr. Cotman sent to me for inspection three boys who were engaged in a Vanilla factory. They had all become the subjects of a copious eruption of very minute lichenoid spots over the whole face and forehead. There was present also slight erythema and a little desquamation in parts. The rash was almost confluent. The boys said that the vanilla stained their hands, but they did not consider it irritating. Their

hands looked dusky and were slightly erythematous. The eruption was probably fading when I saw it. Dr. Cotman had in the first instance been consulted by one of the boys, and had on inquiry discovered the others.

No. LXI.—*Recurrent Varicella—Question as to hereditary Syphilis.*

A little girl, three years old (Miss W. W——), was brought to me under the following circumstances. I had attended her father for syphilis, and, four years after the disease, had told him that he might quite safely marry. He had done so, and both he and his wife had remained in excellent health. Their only child, my present patient, was born about a year after the marriage, and was carefully watched in infancy by a surgeon who knew the father's antecedents. Nothing in the least suspicious of syphilis occurred during infancy, but when two years old, the child went through a mild attack of chicken-pox. It cleared away completely, but some months later (statements differ as to how many) a rash, exactly similar in character to the first, made its appearance. It was scattered over the body and limbs, and was distinctly vesicular. I received a full written description of this eruption from the family surgeon, who informed me that he had at first given arsenic, but with no good results, and that subsequently grey powder in half-grain doses, night and morning, had appeared to cause subsidence of the symptoms. The improvement had, he said, seemed most definite, and had led him to diagnose the eruption as syphilitic. The tendency to recurrence of the spots had, however, by no means come to an end. Fresh spots had constantly reappeared, and though they did not cause much discomfort to the child they greatly distressed her father. The character of the eruption had, I was informed, become somewhat modified, being in many places bullous rather than vesicular.

I found the little girl florid and healthy looking, and without the slightest indication of inherited taint. The eruption was symmetrically scattered over the trunk and limbs, and it was in all respects like chicken-pox. The spots on drying up pre-

sented little scabs, but had no tendency to ulcerate. Some which had been scratched showed blood crusts. I felt justified in giving a very confident opinion that the eruption was only a recurring varicella, and that it had nothing whatever to do with syphilis.

The sequel quite confirmed this diagnosis. After a time the child got quite well under non-specific treatment. It remains so, I believe, at the present date (two years later).

An unusual point in the history of this case was that an interval of some length was said to have occurred between the original chicken-pox and the recurrence. During this period the child was said to have been quite clear. The liability to recurrence and persistence of chicken-pox is well known. I have entered pretty fully into the consideration of the subject on a former occasion.\*

#### No. LXII.—*Herpes After-pain—Its severity and prolonged duration in the aged.*

All will agree, I think, in the opinion that the severity and duration of herpes after-pains are usually in ratio with the age of the patient. Young persons do not suffer from after-pain from shingles. In old people the pain may last for years. Of this the following case is, amongst many others, a good example.

Mrs. S——, an old lady of 70, suffered from herpes zoster a year ago. She avers that she is still never free night or day from a distressing aching pain in the parts which were affected (ear, neck, and shoulder). The pain does not now shoot and sting as it used to at first, but is rather an unbearable ache. Her nerve pains did not begin with any severity till the herpes spots were healing. This statement applies only to her skin, for the first symptoms which drew her attention to the eruption was a severe pain in the ear. She asserts that she has had earache ever since. I saw her in the first instance on June 16, 1889, at her own house, when she was just recovering from influenza. She was then in bed, and suffering so much from the herpes after-pain, that she could not

\* See "Lectures on Rare Diseases of the Skin," pp. 19 and 227.

bear to be examined, and could scarcely speak to me. Since that she has visited me several times. She is a cheerful person, inclined to make the best of things, and she has now regained very fair health, but her complaints about the pain are incessant, and she will sit and weep during her visit to me. She says that it entirely prevents sleep at nights, and compares it to a gimlet boring into the ear. From the ear it passes down to the clavicle and tip of shoulder.

This is perhaps the most severe case that I have seen, but I have observed not a few which closely approach it. I have known several in which herpetic after-pains made the remainder of the patient's life a state of misery. They were all in old persons. Quinine and aconite are the most useful remedies, but I have had no triumphs.

### No. LXIII.—*Pregnancy a cause of Pruriginous condition of Skin.*

Amongst the constitutional conditions which may cause a general pruriginous susceptibility of the skin we must rank pregnancy. That this state may be attended by what is called prurigo of the genitals has long been recognized, but I do not think that attention has been sufficiently given to its possible influence on the integument as a whole. I will narrate a single illustrative case. A lady who has borne several children tells me that always, during the last three months of her pregnancies, she has suffered from intense irritation of her skin over the whole body and limbs. Nothing that her medical adviser could do ever gave her any relief, but the trouble disappeared immediately after her confinement. There was no eruption until she scratched, and by scratching she often produced wheals, or even sores. Some years after her last confinement she was under my care for pruriginous eczema of the hands (a sago-grain eczema, allied to cheiro-pompholyx); and some years later still, having had her hands quite cured, she had burning irritation on the top of her head, attended (after scratching) by a slight eczematous condition.

No. LXIV.—*On Lupus Necrogenicus, and the stage at which Gland Infection occurs—Its distinction from Lupus Vulgaris.*

That the infective stage in cases of lupus is far more active in the very beginning than it is later on, is well illustrated in cases of necrogenic lupus on the hand.

The following case illustrating this statement was brought to me by my son.

A middle-aged and somewhat delicate-looking woman had large glandular swellings in her left axilla and just above her elbow. They were clearly in connection with a small patch on the back of her hand, which had all the characters of necrogenic lupus, and which she attributed to having pricked her hand while stitching a skin-rug. The skin at which she was at work was dry, and, beyond the fact that it was animal matter, there did not appear any reason for supposing that it contained any virus.

The woman was engaged in cooking, and might easily have scratched her hand on a bone. Whatever the source of irritation had been, the patch was, however, quite characteristic, and was exactly like what we so frequently see on the hands of medical students. It was about the size of a shilling, and not itself inflamed or ulcerated. It was somewhat thickened, and had in the middle a closely adherent crust which could not have been removed without making it bleed. Taken in conjunction with the swelling of the glands, it had given rise to the suspicion that it might be a primary specific sore; neither my son nor I had, however, any hesitation in putting aside this suggestion, for there were no constitutional symptoms, and the glandular swellings were acute and threatening abscesses. Her condition was, in fact, exactly what I had myself passed through in student life in connection with post-mortem pricks.

I advised that the patch on the back of the hand should be promptly destroyed by the acid nitrate, and that the threatened abscesses in the glands should be repressed by evaporating lotions if possible, but opened, as early as might be, should suppuration occur.

It may be convenient here to discuss the question as to whether these patches of so-called necrogenic lupus are due to the introduction of tuberculous matter, or to any other form of particulate virus. That they occur to dissectors and to cooks, and that they are in connection with scratches and pricks whilst dealing with animal matter, is, I think, beyond any question. That they occur to cooks as well as to medical men is a conclusive fact in disproof of their being in any way connected with the syphilitic virus. Undoubtedly cases of common lupus on the hands and feet not unfrequently exhibit conditions which it is difficult to distinguish from the necrogenic form. Still, however, I think that there are differences which should be recognized. Thus lupus vulgaris scarcely ever causes glandular enlargements, whereas implication of the glands and the formation of more or less acute abscesses are exceedingly common, indeed almost the rule, in these necrogenic sores on the hands. On the other hand, the necrogenic sore, after the first stage of more or less acute gland-implication is passed, exhibits far less tendency to serpiginous spreading than does lupus vulgaris.

My own personal experience in this matter has been so instructive that I may perhaps be pardoned for relating it. In my student days I got, of course, many needle-pricks, bone-scratches, &c. on my hands, and on the knuckles of my left hand three distinct patches of necrogenic lupus formed almost simultaneously. It may have been that they were all from scratches from the same subject, but about this I cannot tell. I was at the time constantly engaged in dissection and post-mortems. I do not remember much about the very earliest stage of the sores, but certainly they were never attended by any indications of acute infection. Sub-acute glandular enlargements promptly occurred above the elbow and in the arm-pit. Large chronic abscesses resulted, which, having been opened, the sinuses left were slow to heal.

In both situations I well remember that incisions had to be made several times. I was much out of health at the time, and had to desist from work on account of the abscesses for at least four months. No one at the time advised any radical treatment for the original sores, but some years later when

they had passed into a quite chronic condition I repeatedly applied the caustic acid nitrate of mercury. By this means two of the patches were completely cured, a thin inconspicuous cicatrix alone remaining. I have now to ask attention to a fact which is, I think, really remarkable in reference to pathological laws. The treatment being inconvenient inasmuch as it disabled my hands, I desisted from it as already said, leaving one patch only partially cured. During nearly forty-five years that patch has remained with but little change. It is still in a quite characteristic condition of thickening with a closely adherent epidermic crust. In summer it gets almost well, and in winter, in accordance with the general law as regards lupus, especially when on the extremities, it usually inflames more or less. There has never been the slightest tendency to irritation of the glands since the first occurrence of abscesses, nor has there been any production of satellites nor any serpiginous spreading of the patch.

These facts, I think, conclusively show that there is something in the necrogenic lupus which stamps it as distinct from vulgaris. Yet I believe that the tubercle bacillus has been found as frequently in connection with the one as with the other.

That the irritating material which produces the necrogenic patch is of the nature of tubercle seems to me exceedingly doubtful. I am much more inclined to associate it with the virus which occasionally causes acute blood-poisoning, preceded by lymphatic inflammation. From this latter it appears to me to differ only in degree of virulence.

No case can, I think, better illustrate the importance of vigorous local treatment than my own. The patches which were thoroughly destroyed have remained perfectly well, whilst that which was not so treated has well illustrated the power of local persistence of a form of chronic inflammation through a long series of years.

No. LXV.—*Note on the Diagnosis between Erythematous Acne and Lupus Erythematosus.*

Although the bat's-wing form of eruptions on the face is

very characteristic of lupus erythematosus, yet we must by no means trust to it for differential diagnosis. Other eruptions may produce very similar appearances. I have just seen two patients whose faces illustrate this remark; in one of them the disease being really a form of acne rosacea, in the other a dry eczema, due to exposure. In the first of these cases the patient, a gentleman of thirty-one, had been told that he had been the subject of lupus erythematosus, and as such was sent to me by a very able dermatologist. I will state my reasons for dissenting from this opinion. The condition was one of diffuse redness of the whole nose, especially of its tip, and it extended on each side quite symmetrically upon the middle of the cheeks. The erythematous patches were, however, ill-margined, and on the cheeks were attended by that condition of dilated capillaries which is so aptly compared to red sea-weed. These sea-weedy dilatations were to be seen on other parts of the face, and nowhere were there erythematous areas with well-defined and aggressive edges. On looking critically at his nose it was seen to be spotted all over with little comedones, and the plugs of sebaceous matter were squeezed out with great ease, being rather softer than usual. Now true lupus erythematosus, when attended with comedones, usually assumes the dried orange-peel condition; and the plugs of sebum cannot be ejected without much trouble. Taking this feature of marked difference into consideration, and with it the fact that the erythema was never circumscribed, I feel justified in claiming the case as one of diffuse rosaceous acne, and not lupus.

No. LXVI.—*A form of Psoriasis which was not attended by desquamation, and which left scars—Easily cured for a time by arsenic, but persistently relapsing for forty years.*

A gentleman, now aged about 64, has been for more than forty years the subject of "psoriasis." He has been under almost all the English dermatologists and several of the continental ones, and those who gave it a name always said "psoriasis." He has taken much arsenic, and has always

found himself better for it, the eruption having often been cured in the most definite manner by it. Yet the eruption presents some curious features of distinction from common psoriasis. When he came to me he had only a few patches in the middle of the back. I noticed that they were irregular in shape as if serpiginous, and that they were leaving scars. On mentioning this, Mr. — at once said, "Oh yes, it always leaves scars; they wear out after a time, but at first there are always slight scars." I noticed also that the scale crust was very thin and firmly adherent, and asked whether at any time when the eruption was copiously out he had been troubled by the shedding of scales into his bed. "Never a scale," was his reply. Here, then, we have a "psoriasis" which never sheds scales and which leaves scars. Another feature of difference I have yet to mention, and it is this, that Mr. — assured me that when the eruption relapsed it never came to the old places, but always to new ones. It did not appear to have ever been definitely symmetrical, and had not specially affected the elbows and knees.

It may be thought that this eruption more nearly resembled a multiple lupus than true psoriasis; but, in reply, I must assert however that it had always yielded most definitely to arsenic, and that it had never visibly ulcerated, and that the scars left were of the most trivial character. Probably it is a hybrid between psoriasis and lupus, but partaking more of the characters of the former than of the latter.

No. LXVII.—*Eczema Marginatum on one leg subsequent to a similar affection of the Groins, &c.*  
—*Residence in the Tropics.*

A married gentleman, aged 36, under my care in 1891, showed a most remarkable example of eczema marginatum. His left leg was almost covered from ankle to knee by one immense patch. Its borders were as abrupt as possible, but there were in many places little satellite patches, and minute pustules near to them. I was told that the chief mode of spreading was by satellites, which coalesced; but I doubted

this, for its slightly raised border had all the appearance of a serpiginous progress. The general surface of the area involved was smooth, of a red plum-colour. The edge was slightly scaly and a little raised. I took some scales from the latter for microscopic examination. He had a small patch of quite recent formation in the right crutch. Mr. T——'s history was that the patch, as I saw it, and as it is displayed in a portrait then taken for the College of Surgeons, had been present only eight months, but he had suffered from the same disease on several former occasions. He had lived much abroad, and it had repeatedly relapsed in hot climates. It had always been called "*eczema marginatum*," and he had been cured on one occasion by Goa powder, and on another by Harrogate water baths. All his life he had, indeed, been subject to occasional skin irritation. Even as a boy, if he perspired much, spots of *lichen marginatum* would appear on his chest, and if he took port wine it invariably brought out erythematous and very irritable patches of what he called psoriasis, but which never lasted long. He did not think that he had ever in his life had *pityriasis versicolor* or true ringworm. He was of gouty family.

The *eczema marginatum* developed for the first time in 1881, and affected the skin of the thighs in contact with the scrotum. It was very bad, and took a long time to cure. From 1881 to 1885 he resided in England, and was almost free. In 1885, and from that to 1887, he was again attacked whilst again residing in the tropics. On this occasion he had patches on the left leg and right thigh. From June to October, 1888, he was at Harrogate, using the baths, and at length got well.

It is interesting to note in reference to the difficulty of transferring a malady concerning which we could not doubt that it spread by contagion in the part affected, that Mr. T—— had never infected his wife, nor had patches developed on the other leg, although, of course, constantly in contact with the affected one.

After prolonged examination, neither my son nor myself could find any trace of fungus in the scales which were scraped from the patches.

A portrait of the leg was taken by Burgess for College of Surgeons, November, 1891.

Another trial of Harrogate and of various local applications has not succeeded in wholly curing the disease.

The points in the case are—1st, the probability that the eruption was of cryptogamic causation in the first instance; 2ndly, the absence of fungus now; and, 3rdly, the very definite influence of hot climates in causing relapses.

#### No. LXVIII.—*Alopecia after Ringworm.*

Mr. H—— brought me one of his sons, a cadet of eighteen years of age, who had three patches of alopecia areata on different parts of his scalp. They presented all the usual characters. I asked as to ringworm, and was told that the patient and a brother of his had suffered from it six years ago. In the patient there had been only a single patch so far as had been observed. It had lasted, however, a considerable time. The part which Mr. H—— believed to have been originally the site of the ringworm was not affected by any one of the alopecia patches, but there was one near to it.

#### No. LXIX.—*An Elementary form of Kaposi's Disease.*

Two girls, sisters, the Misses McC——, one aged 14 and the other 13, were brought to me on account of a peculiar condition of the face, which was, I think, a minor form of Kaposi's disease. In the first place, both of them were very much freckled, the upper part of the face in each, eyelids, forehead, &c., being covered with brown patches. It was winter when I saw them, and I was told that these freckles became much more conspicuous in summer. In addition to the freckles, both were liable to have the skin become rough in patches on the face with the development of very minute lichenoid spots. The elder sister had been liable from infancy to a slight form of intertrigo. With this exception the limbs of both the sisters were exempt. Both the girls were in excellent health with the exception that the younger one was liable to bilious

attacks. It will be seen that there had been no evidence of a tendency to ulcerate or inflame in either of the cases. In degree of severity the disease was far below what we witness in the marked examples of Kaposi's malady. In the essential feature, however, of remarkable proneness to freckle, and of development of similar conditions in more than one member of the same family, the disease coincides with that affection.

## ON CANCER.

(Continued from Vol. III., page 342.)

### *Infective Senile Freckles in association with Malignant (Epithelial) Growths—Three cases—Comments.*

Every one must have noticed how remarkably cases which illustrate new views multiply as soon as their peculiar features have been recognized. I have just had an instance of this reference to the infective freckles of elderly persons which I have recently described, and have associated with tendency to malignant growth. During one week two new examples of this association have come under my observation, and in neither case was the patient sent to me because I had written on it. More recently still a third case has come under notice, but in it there is as yet only melanotic staining without any ulceration. These three cases may be briefly recorded as follows:

CASE I.—Dr. G—— is now 73. He has on the bridge of his nose a considerable area of coal-black staining, the margins of which are irregular and are evidently extending. On the eyelids of both sides are some indefinite black freckles. The condition, however, of most importance is a papillary patch on the right cheek about as big as a sixpence, and evidently an early stage of epithelial cancer. It is quite black, but being rough and warty it is difficult to be sure that it is really pigmented. Dr. G—— is in excellent health. He has known of the freckles on the nose for six years or more, and of the malignant patch on cheek for nearly two. I take his case to be another example of the association of epithelial cancer with pseudo-melanotic staining, of which I have recorded examples in Vol. II. p. 85, and Vol. III. p. 321.

CASE II.—In my next case the patient is much younger. She

had herself applied the term "freckles" to her black patches, although, so far as she remembered, she had not in youth been liable to freckle. Mrs. P. T—— is only 39 years of age, but is more senile than her years denote. She is the subject of acne on her chin, and of acne-prurigo over the whole face. She has also suffered from nettlerash. She has on her right cheek a black patch as large as a shilling, which she says began as a freckle five years ago. It is now distinctly papillary in the middle, and is both spreading and growing. She denies having ever had any mole on the affected part. I have no doubt that the "freckle" is passing into epithelial cancer, and have insisted on the importance of its complete destruction.

CASE III.—Mrs. S——, an old lady of 71, who has enjoyed excellent health through life, now suffers from chronic rheumatism. She has a conspicuous black patch on her right cheek, and near to it some smaller ones. There are some of a less well-marked character on the other cheek, and one or two florid naevi.

It has so happened that in all the cases which I have yet seen of this infective senile melanotic staining, it has been the right cheek which was chiefly affected. This is contrary to what occurs in xanthelasma of the eyelids, in which almost invariably the left side takes precedence.\*

To these cases I am able to append another which illustrates the same sequence of events—melanotic staining of tissue long preceding malignant growth. The part affected was, however, not a senile freckle, but the mucous membrane of the mouth in a patient not past middle age.

*Black Pigment-staining of Gums and Cheek, preceding by a long series of years the development of Malignant Growths in the Gums.*

Mr. Willett was good enough to give me an opportunity (May, 1891) for examining a very important example of this

\* Should any of my readers have opportunities for inspecting the cheeks of aged persons and observe the black stains to which I refer, I shall be much obliged by information as to which side the patches chiefly occur on. My impression is that in slight forms the condition is not uncommon.

state of things in a case which was under his care in St. Bartholomew's Hospital. The patient was a woman of about forty. Black patches had been gradually spreading on the gums and cheek of her left upper jaw and buccal pouch, for more than fifteen years. She attributed the first appearance of staining to the irritation of a tooth plate. For long there had been nothing but coal-black staining without any thickening, but of late (the last two years or so) the gums had shown tendency to fungate. A portion of diseased gum had been cut away at the Croydon Hospital six months ago, but the growth had recurred, and for this she now sought Mr. Willett's aid. The gum presented an irregular outgrowth which had an uneven surface with small polypoid projections. The growths were everywhere coal-black. It was ulcerated where the teeth had been, but presented a quiet condition, and was not unhealthy. On the adjacent parts of the cheek and lips there were large conspicuous patches of coal-black staining. This resembled the colour in mouths of dogs, only much blacker, and arranged quite irregularly. It was not attended by the slightest thickening.

Mr. Willett cut away the diseased gum on May 18th, and removed at the same time as much as could be taken of the stained mucous membrane. It should be stated that no enlarged glands could be found. Mr. Willett will probably record the case in detail with microscopic examination, and it will be of much interest to know whether the new growth is to rank as sarcoma or epithelioma. My interest in the case is chiefly in that it affords another example of a change which may be counted as little more than physiological aberration existing for a long series of years with infective spreading, and ending at last in the local production of malignant growth.

*Unusually long interval between Excision of Cancer of the Tongue and implication of the Glands.*

I have had recently two remarkable cases in which the interval between the excision of a cancerous sore on the tongue and the development of gland disease was unusually

prolonged. As a rule in epithelial cancer, if after a successful operation, so far as the primary disease is concerned, the glands do not enlarge quickly, they will not enlarge at all. After the expiration of six months from the date of the operation, I have usually felt tolerably confident that the disease would not return. In each of the two cases to which I have now to refer, however, the first manifestation of gland disease has occurred after an interval of twenty months, during the whole of which the scar of the operation has remained perfectly sound, and there has been not the slightest trace of lymphatic engorgement. Such a result has been, I repeat, in my practice very exceptional. In both of the cases the excision was done at a very early stage of the disease. In one the cancerous ulcer was not so big as a sixpence and quite superficial, and confident opinions had been expressed that it was not cancerous at all. I removed it, however, very freely, according to my invariable rule in such cases, which is to operate, if possible, in the precancerous stage of cancer. The microscope proved, however, that the little ulcer really was malignant, and, as stated above, the glands have confirmed this verdict by taking on enlargement twenty months after operation. In this case the patient is an elderly gentleman, a distinguished author, of more than seventy years of age. In my second case my patient is a lady under forty, who showed me a suspicious sore on her tongue, which was attributed to the scratching of a tooth. I advised and performed an immediate excision of about a third of the organ. It healed well; she had no trace of gland enlargement when the operation was done, nor did any occur till rather more than twenty months afterwards, when she came to me with the tongue perfectly sound, but a mass of enlarged glands under the upper third of the sterno-mastoid. In each of these cases at the time that I saw the patient for the recurrence of the disease in the glands, the circumstances were such as to discourage me from further operation. The enlarged glands were placed under the upper third of the sterno-mastoid, and there were several of them. In such cases I have never found that an operation was of real advantage to the patient.

*Epithelial Cancer at Early Ages.*

In 1889 I operated upon a brother and sister for epithelioma at somewhat unusually early ages. The brother was forty-two years of age, and the sister only thirty-four. In the brother the growth was in the hard palate, and in the sister in the right labrinum majus. In both the microscope confirmed the diagnosis. Both were quite well two years afterwards, and, so far as I know, are so at present. The only family history forthcoming in this instance was that a great-aunt had died of cancer of the breast.

*Resorcin in the treatment of Rodent Cancer.*

A gentleman who was the subject of a superficial and small rodent ulcer on his nose had been treated by me repeatedly by applications of the acid nitrate of mercury. Temporary cures were obtained, but in six or eight months he usually returned, requiring another use of the caustic. He has been good enough to write to me from India to let me know that a complete cure has, he thinks, been obtained by the employment of a resorcin ointment, 20 to 40 per cent.

*A Quiet Bronchocele becoming Malignant.*

The transition from non-malignant growth or even from hypertrophy is, I believe, not unfrequently witnessed in the case of the thyroid gland. An instance of this I find recorded by the late Mr. Dulfon, of Birmingham.\* A woman of sixty had been the subject of quiet bronchocele from girlhood. It had caused her no inconvenience until three months before she came under Mr. Dulfon's notice. It then became very hard and increased rapidly in size. The increase was chiefly on the left side. Both trachea and œsophagus became compressed, and she was unable either to swallow or to lie down. Death from asphyxia followed in about five months from the beginning of the enlargement. The tumour on examination presented "a soft pulpy mass of a medullary character throughout." The late Mr. Hodgson, who spoke in the discussion, said that he had seen an exactly similar case in a man.

\* Birmingham Pathological Society, Oct. 5, 1841.

## RHEUMATISM AND GOUT.

### No. XVII.—*Anchylosing Rheumatism and Spondylitis Deformans—Antecedent Gonorrhœa and Stricture.*

A remarkable example of this was shown to me in the Lambeth Infirmary by Dr. Lloyd (Oct. 13, 1891). The patient, a rather florid man, aged 54, had suffered for twenty years, and was almost literally one piece of bone. Knees, ankles, and hips were quite stiff, and so were his elbows, shoulders, and wrists. The last-mentioned joints were still somewhat swollen, and not absolutely ankylosed. His hands and feet were distorted, and all his digits bent into the palm. His hands lay on his chest, and he could not lift them. His lower jaw was ankylosed, but he could still eat when food was put into his mouth. He had formerly been in better circumstances, a traveller, I think, and he attributed his attack to his having been put into a damp bed. He had never had acute rheumatism, and his symptoms had developed very gradually. For a long time he helped himself about with sticks, then for six years he went about on crutches, then for eight in a bath-chair, and finally he has been for seven bedridden in the Infirmary. He said that he was never free from aching pain. He has been for many years the subject of stricture, and had had gonorrhœa before the rheumatism set in. As regards family history, it is not known that any of his relatives have ever suffered from either gout or rheumatism. The whole of the spinal column, with the exception of the neck, appears to be stiff.

I attach great importance to the history of gonorrhœa and gleet as predisponents in this case. It is further very possible that the patient does not know his family history in reference to gout.

No. XVIII.—*Neuritis in one eye only with gout, in a woman—Retinal hæmorrhages in the other.*

A woman, aged 37 (Amy N——), had experienced several attacks of gout in her toe, one of them a severe one. She was a liberal beer-drinker. Her paternal grandfather had suffered from gout. When she came under my care, she had been for a year nearly blind in her left eye, and the disc showed atrophy and great diminution of vessels. In the other eye were recent hæmorrhages into the vitreous and retina. There were casts in the urine, but no albumen.

No. XIX.—*Ulceration of Legs—Hydrops Articulorum affecting symmetrically the Wrists and Ankle, and in association with congenital looseness of joints.*

This lady had been born in India, but had been brought to England in childhood. She did not know much as to what maladies had occurred in her family in previous generations, but there was a tradition that one at least of her relatives had suffered from gout. One fact was quite certain, that in several generations a very remarkable laxity of most of the joints had been noticed. Thus she could herself throw her first phalanges backwards on the metacarpal bones almost to a right angle, and most of the phalangeal joints admitted of some lateral movement, and all felt loose. She could make her elbows touch behind her back without much effort, and she believed that she shared these peculiarities with several relatives. One of her own children, she said, had joints just like hers.

Mrs. ——— was sent to me on account of “a peculiar form of swelling in the neighbourhood of several joints.” Dr. Bain Sincock, of Bridgwater, who sent her to me, informed me that he had opened one on the wrist, thinking it might be a ganglion, but had found that it could not be removed. On first sight of the wrists I made no doubt that she was the subject of ganglia, one on each side, at the back of the wrist, but further examination induced me to alter this opinion and to think that the swellings were bulgings of the synovial mem-

brane. The principal swelling was placed lengthways at the back of each wrist on the ulnar side, and was two inches long and fluctuated freely. The extensor tendons were little if at all lifted, but on the radial side there was another swelling less elongated but broader than the first. On the front of the wrist there was no perceptible swelling, but pressure on those of the back convinced me that a certain degree of fulness could be produced in front.

I had no hesitation in believing that the two swellings on the back of the wrist communicated under the extensor tendons. The ganglion-like swellings were quite flaccid when the hand was straight, and became tight when it was bent backwards. The whole wrist was very loose, the bones could be moved in almost any direction, the degree of movement between ulna and radius was far greater than usual, as was that also of the pisiform bone. Thus there appeared to be a general tendency to synovial effusion, but wholly without inflammation. There was not the slightest tenderness, and excepting that the wrists and fingers were weak, the patient stated that she could use her hands freely. She was still accustomed to play the piano, but complained that exercise sometimes made them ache. The amount of effusion into the left wrist was much less than that into the right.

Mrs. — had not in the first instance complained to me of her ankles, but on my inquiring whether any other joints were affected, she then told me that for many years, indeed almost from childhood, her ankles had been weak and swollen. She had formerly often fallen, from twisting her ankles. I found on examination that there were large swellings bulging beneath the malleoli on both sides in both joints. Like the swellings about the wrists, these were quite painless, unattended by the slightest thickening, and freely fluctuating. It appeared probable that the swelling had increased considerably of late, but Mrs. — was certain that it had been present in some degree for several years.

There appears no reason to doubt that we have here to deal with a case of almost passive *hydrops articuli* affecting symmetrically the wrists and the ankles—joints which are very seldom indeed the seat of that malady. There had

never at any time been effusion into the knees, nor had the patient ever suffered from acute rheumatism. She was apparently in tolerably good health, though of somewhat feeble circulation. In early life she had suffered from chilblains, but not recently. It is not improbable that the family history of remarkable laxity in the ligaments, &c., of the joints was in a not unimportant connection with this tendency to passive effusion and distension.

Although not acting as a cause, it may yet have permitted in an especial manner its formation. It may indeed have been itself an evidence and result of chronic arthritis in some predecessor, and although I must admit that the facts that were forthcoming as to family history were not strong, I yet feel little doubt that the real cause of the affection was inherited gout.

No. XX.—*A Case illustrating Peripheral Neuritis in Gout.*

A few general statements appear to be true of all forms of inflammation directly due to gout. They are all transitory, and although they may be very severe, they seldom disorganize the structures affected. Although by no means invariably so, the pain which attends them is as a rule much in excess of the other phenomena. These statements apply, I believe, to those forms of peripheral neuritis which are associated with gout. Of these, Sciatica, in some of its forms, is perhaps the most marked example. In gouty sciatica large areas of skin may become numb and painful, and groups of muscles may become weak, but the anaesthesia and the paralysis are never complete, and they both of them disappear almost wholly when recovery takes place. Although we may quote sciatica as the most striking and best known example of gouty neuritis, it is far from being the only one. Other nerve trunks or plexuses may suffer in a precisely similar way, and thus in the case of the arms we may have brachyalgia under precisely the same conditions and with parallel results. I have seen many examples of this, and many others of neuritis of smaller and isolated nerves in various parts. The anterior crural is, I believe, very rarely affected, and the case to be narrated is

almost the only example of it in a severe form which I can at present remember to have seen.

Mr. A. G. D——, a gentleman of sixty-one, of large frame, and who, although strictly temperate, had lived liberally, consulted me on January 25, 1892. It was on account of lameness and numbness in the left lower extremity, consequent on an illness which had begun five months ago. He described himself as having suffered “all the forms of torment mentioned in Foxe’s Book of Martyrs.”\* His attack had begun by pain in the parts on the front of the thigh and about the knee. For this he was sent to Bath, where he rapidly got worse, and was glad to return home and keep his bed. The pain now became excruciating. It came on in paroxysms and assumed various forms. The skin of the front of thigh would burn and tingle, and sometimes felt as if pierced by a thousand red-hot needles. At other times a pain which he named “the carpenter” would come on, and which he described as like having his bones sawn or chiselled. He could not endure the slightest touch to the skin or a breath of air on it at the time the pain was on. In addition to the pain the skin felt numb. Various remedies were tried, but with very little effect, and it was not till after two months that he was able to leave his room. Whilst confined to bed he had an attack of acute gout in the great toe of the other foot, and he experienced also several severe paroxysms of difficulty in breathing and pain at the heart, one of which he believes was nearly fatal. They were relieved by inhaling nitrite of amyl, and were no doubt of the nature of angina.

Mr. D—— believed that when he left his bed the muscles in front of his thigh were quite wasted. When he came to me they had recovered to a considerable extent, but were still not nearly so good as those of the other limb. He could lift the limb and kick fairly well. At this date the tenderness of the affected areas of skin had quite disappeared, and he could bear to have it slapped or pinched, but certain parts were

\* The following terms were used to describe the pains: “Burning, lancing, hot irons, ice, hot needles, electric hammers, and various others, the utmost nature could bear.”

still partially numb. There had never been any pain or numbness in the back part of the limb, nor in the leg much below the knee. A distressing sensation which still persisted was, as he described it, as if the knee were fixed in a case. The distribution of the numbness had been pretty exactly that of the external, middle and internal cutaneous nerves, but I failed to detect any evidence of implication of the long saphena.

Mr. D—— had been seen by several physicians before coming to me, and had been assured that his kidneys, heart, &c., were healthy. He said that his urine at one time had been so loaded with uric acid that it looked like a mixture of red lead. He was not aware of any history of gout in his predecessors, but in this matter his knowledge was no doubt at fault, for his eldest son had suffered from gout before he did himself, and from his statements it seemed probable that most of his children were prone to pass uric acid.

Mr. D—— could, with the help of a stick, walk fairly well at the time of his visit to me, and he was still improving. His muscles were gaining in strength, and his skin was losing the sensation of numbness. He had been carefully treated, and had been restricted to whisky and water.

A very important fact remains to be added to this history, although it is one which possibly had no close connection with what has been described. Mr. D—— had the ulnar nerve in his right arm, or at any rate its motor part, in a state of almost complete paralysis. There was a conspicuous hollow between thumb and forefinger visible behind, and the muscles of his little finger were wasted. He could use his interossei somewhat, but not well. He was well aware of this peculiarity, and it had been carefully examined by other observers. It had been developed three years ago in direct connection, as he believed, with his having carried a heavy portmanteau a considerable distance. A few days later he found the arm aching and weak, and had a "sensation of funny bone" at the elbow. He denied that there had ever been any loss of sensation in the parts supplied by the ulnar nerve, and certainly none could be proved when I saw him. If the neuritis which led to this condition were gouty, it must be

admitted that it had been almost wholly painless, and that but little restoration, as regards the muscles, had taken place. I am inclined rather to consider it as an instance of paralysis from overstrain and of the same nature as the cases recorded in ARCHIVES, Vol. III. p. 239. As regards the anterior crural, the facts seem to me conclusive. That the patient was in a gouty state at the time was undoubted, and the symptoms indicated that all branches of the nerve, with the exception of the terminal filaments of the long saphena, were affected. In explanation of the extreme pain, and especially of the tenderness of the skin, I would suggest that not improbably the end-organs were themselves implicated.

No. XXI.—*Symmetry in Hand-changes in Rheumatic Gout—Inheritance of true Gout on both sides.*

In November, 1891, Dr. Hack Tuke brought to me a lady who presented a very interesting example of symmetry in rheumatic gout. It was acro-arthritis so far as the last joint of the index and little fingers of both hands were concerned. Of these fingers, the last joint was in all more or less disorganized and the terminal phalanx somewhat displaced. In every case this last phalanx was twisted laterally towards the next finger; thus the end of the little finger pointed to the ring finger, and the end of the index towards the middle finger. In the thumbs all the joints were somewhat affected, but the stress of the disease fell on the proximal one. This latter, the carpo-metacarpal, in both hands was very much thickened, the end of the metacarpal bone being considerably enlarged. The two hands were in all respects exactly alike.

Miss H—— was a little, nervous, energetic lady of 61. She had, on the whole, enjoyed good health. She told me that both her parents had suffered from regular attacks of true gout, and that her father, who was a surgeon, had warned her that she must not take malt liquor or wine. She herself had never had an attack of true gout nor any acute attack of rheumatism. She had suffered much from neuralgic headaches in cold weather.

## MISCELLANEOUS CASES.

### No. LI.—*On the Spider-Nævus.*

I wish to describe a form of nævus with which I have long been familiar, but which has, I think, not as yet received much special recognition. Its peculiarity consists in that it has a distinct centre, from which branches radiate in all directions. Its centre is very small, but is so definite, and apparently so active in filling its tributaries, that it might be compared to a minute heart. The size of the nævus is rarely greater than that of a fourpenny-piece or a sixpence. The condition of branching out from the centre suggests a resemblance to the small body and the long limbs of some insects, and thus I have been in the habit of naming the whole the "spider-nævus." \* If you put the finger on the middle of one of these nævi it may be completely emptied with but slight pressure, but the refilling when the finger is removed is instantaneous. The "spider-nævus" is never congenital, nor have I, so far as I can remember, ever seen it in very young children. After the age of five, however, it becomes common, and it is far more frequent in young persons than in adults. I have, however, recently destroyed a nævus of this kind, and of very well marked characters, on the temple of a gentleman of thirty-two, who held that it had been present only two years. Most of the cases which I have treated have been in young girls between the ages of seven

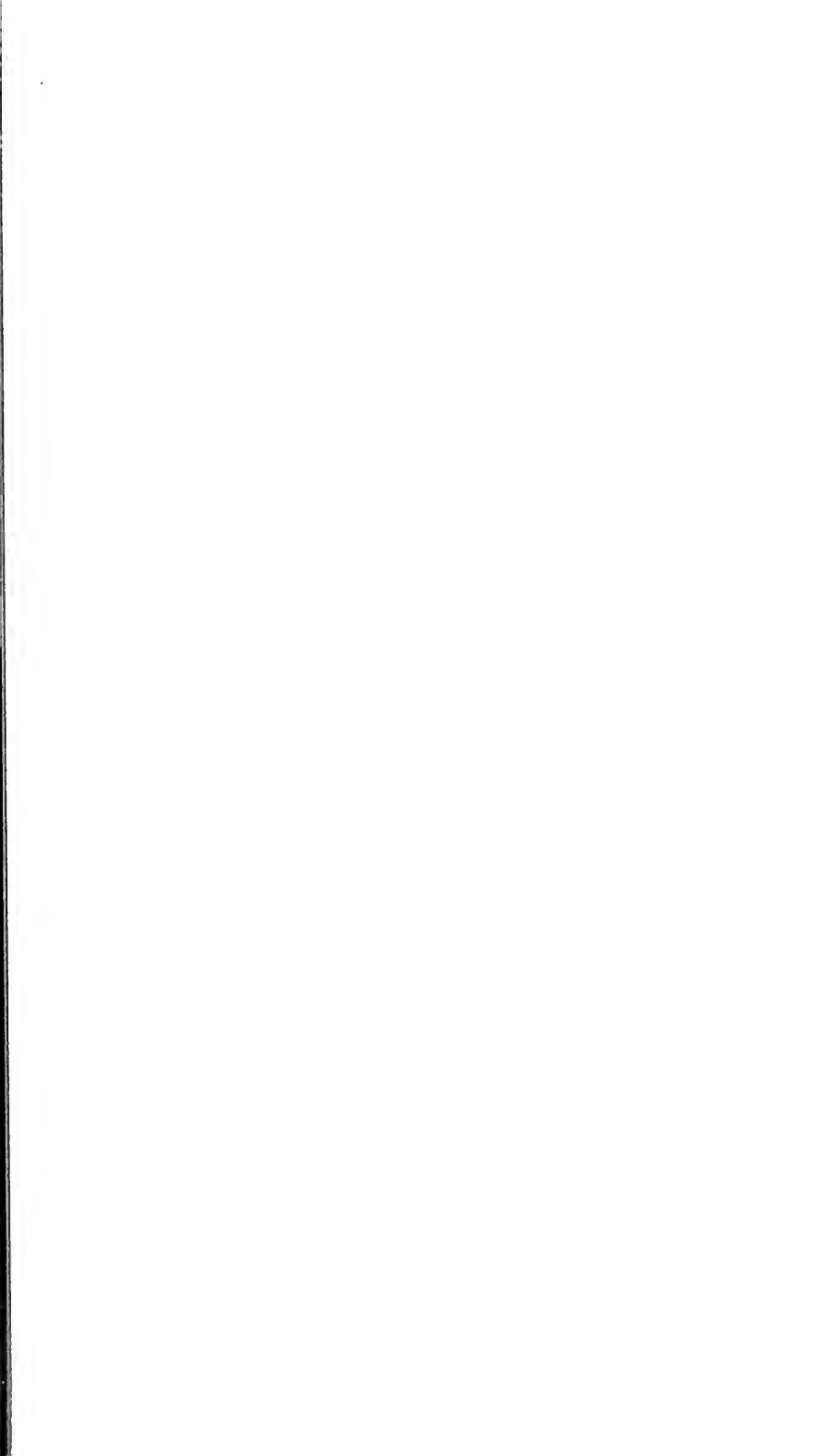
\* I am aware that in using this name I am only reviving one which was familiar to our ancestors. They had a "*Nævus araneus*." The name has, however, lapsed, and I am not acquainted with any definition which was ever applied to it. It may possibly have been used for exactly the same condition as that to which I now wish to apply it. If so, however, I have quite failed to find in the older surgical works any parallel description.

and fifteen. I have seen far fewer in boys, but this may be because the disfigurement is less thought of in them. By far the most usual position of this *navus* is the tip of the nose, but it may occur on any part of the face, and they are not unfrequently multiple. I have treated many of them, mostly, I think, on the children of my professional friends. It is sufficient to destroy the centre by a light touch of nitric acid. The limbs of "the spider" will usually afterwards shrivel; if they do not do so, they also may be lightly pencilled out with the caustic. It is essential not to do too much at first, or a scar may be left more disfiguring than the original stain. The operator should bargain to be allowed to use the caustic several times if necessary rather than do too much at once. The "spider-*navus*" always begins at its centre as a little red spot. It tends to grow, that is to develop longer and longer limbs, for a year or two after its commencement, but not, I think, indefinitely.

It might be of interest to speculate upon its anatomical peculiarities. I have little doubt that, although not itself usually perceptible at time of birth, it takes its origin in congenital peculiarity of structure. That its centre is in some slight degree pulsative seems highly probable. It is in the possession of this definite centre that it differs from all other forms of *navus*.

#### No. LII.—*Nævi on the Hands.*

It is but very seldom that the extremities are affected by *navus*. I have scarcely ever seen them on the feet, and but very rarely on the hands. I was myself the subject of an exception in this matter, having had from boyhood two little *nævi* placed symmetrically in the lower part of the palm of each hand, about two fingers' breadth above the wrist. They did not project above the level of the skin, and did not cause the slightest inconvenience, not being larger than pins' heads. They were easily emptied by pressure. As a boy, I used to amuse myself by noting how exactly they fitted, the one upon the other when the palms of the hands were placed together. I had neither *nævi* nor moles on other parts of the body.



## PLATE LXXVIII.

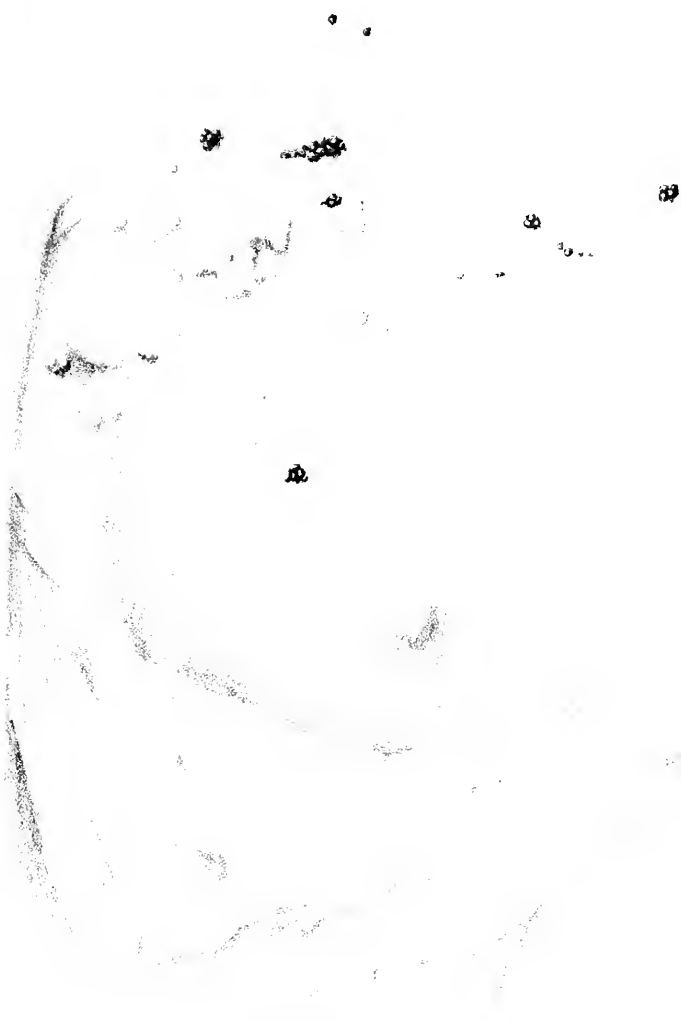
### LUPUS LYMPHATICUS (LYMPHANGEIOMA).

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THIS portrait represents the condition of the disease in Miss D—'s case before the operation. The description of the cure will be found on p. 75. Miss D. was a young lady of 18, in excellent health. The history was that something resembling a nævus or port-wine stain had been observed in early childhood, although nothing had been noticed at birth. An excision operation for a so-called nævus had been performed by a London surgeon in childhood. Of this the scar which remained is shown in the drawing. After this operation, the little lymph-warts, which are characteristic of the disease, began to increase in number, and to extend over the upper part of the breast. Gradually the condition of things here depicted was produced. The so-called warts were vesicles with firm walls, which contained lymph-fluid. Near to them, and sometimes upon them, were numerous little tufts of dilated capillaries, which contained blood, and which could not be emptied by pressure. Some of these were almost black in tint, and others brown, like grains of cayenne pepper. The pathological process was clearly an infective one, and the disease had advanced by the production of satellites near to the original growth.

This case is a typical example of the disease to which some years ago I gave the name of *Lupus lymphaticus*, and of which a full description, one by the late Dr. Tilbury Fox, and another by myself, will be found in the *Pathological Society's Transactions*. Dr. Fox was the first to describe its pathological anatomy. Anatomically it consists of persistently dilated capillaries and lymph-spaces, and may be named, as it has been by most dermatologists, *Lymphangeioma*. Clinically, however, it is an infective and scirrhous malady, and very prone to attacks of erysipelas. It is curable only by complete destruction of the morbid elements. The features just named appear to me to place it in close alliance with lupus, although of course constituting a separate group in that family.

Compare with Plate XVI. in Vol. I.





About the age of forty I noticed one day that one of my spots had disappeared and that the other was still there. In the course of two or three weeks, however, the second had followed, and there has never since been the slightest trace of their existence.

A gentleman named Mr. A F——, who was under my care for another matter, was the subject of a superficial nævus on his left hand. It was a sort of port-wine stain, and involved in irregular patches the palm and the palmar aspects of his thumb, index and middle fingers. It extended also in some parts to the backs of his fingers, reaching the nails, but did not implicate the latter. He had none on the other hand. He believed that they had remained through life (he was about 50) just as they were in infancy, without showing any tendency to extend.

No. LIII.—*Results of Treatment in a Case of Lymph Angeioma (Lupus Lymphaticus).*

Oct. 29, 1891.—Miss B——, for whom eighteen months ago I used the actual cautery very freely for the destruction of lupus lymphaticus on the mammary region, has returned to-day for inspection. (The condition before treatment is shown in Plate LXXVIII.) The result has been most satisfactory. The scars left are by no means conspicuous, and there has been no return of the lymph-vesicles. About half a dozen little "cayenne-pepper grains," scattered in different parts of the affected area, are all that now remain. To these I apply the acid nitrate of mercury. Not a single vesicle can be found. She is greatly pleased with the result, for before the treatment the places had been liable to excoriate and bleed, besides being a great disfigurement. I have preserved an excellent portrait showing the original condition. After the free use of the actual cautery under æther, I repeatedly, during the next six weeks, applied the acid nitrate of mercury to spots which recurred. There seemed to be for a time a strong tendency to reproduction of the lymph-vesicles.

No. LIV.—*On Gynæcomazia in reference to the development of the Testicles—Atrophy of the Testes and overgrowth of the Breasts as a consequence of injury to the Head.*

Since my recent reference \* to this subject, I have found in the Transactions of the British Medical Association the description of a case confirmatory of what was advanced as to the correlation in nutrition and growth between the testes and the mammary glands. A man who had served with the British Legion in Spain, and who was fifty-five years of age at the date of the observation, had pendulous and very large mammary glands, with entire atrophy of one testis and partial of the other. His voice was weak, beard thin and soft, penis small and shrivelled, and sexual desire entirely absent. These conditions had followed, as was supposed, and in conjunction with partial right hemiplegia, as the consequences of a severe blow on the occiput received in a fall. This blow rendered him insensible, and he was for some time under the treatment of Mr. R. Alcock (now Sir Rutherford) in a Military Hospital. Previously to his entering the army he was a married man and had three children, but from the date of the accident all sexual desire was lost, and the changes in the testes and mammae set in. Unfortunately the report before me does not give dates, but as it is said that his youngest child would have been eight years of age, we may assume that the changes had occurred within that period. It is necessary, in reference to such a narrative as this, to exercise a little caution. All depends upon the man's testimony, and he may have been desirous to conceal the real facts and to attribute to the accident that which had really been present from his youth. Arrests of the sexual functions are probably common enough after blows on the head, but I am not aware of any other facts in support of the belief that they are associated with atrophy of the testes or with tendency to gynæcomazia. There is, however, no intrinsic improbability in such consequences.

\* See Arc

ol. III. p. 327.

No. LV.—*Notes on Quinsy.*

Is there any connection between quinsy and gout, or between quinsy and rheumatism? Perhaps the latter is a more likely association. A lady who was liable to attacks of mixed rheumatism and gout, and who was also liable to quinsies, told me that she thought she usually had a quinsy just before her attack of rheumatism. My coachman, who has suffered from severe and definite attacks of gout in the great toe, is liable also to quinsies, but we have not observed any especial association between the two. The clinical history of quinsy is worthy of more attentive study than it has yet received. It is usually a very definite malady differing entirely from all other forms of sore throat. It does not occur in conditions of debility, but to robust and healthy persons, and it is not, I think, associated specially with large tonsils. Only some persons are liable to quinsy, and those who are so have repeated attacks, each one just like the other, and usually with very long intervals between them. In the case of my coachman, above referred to, an interval of ten years of entire immunity had occurred. He has just passed through a very severe attack with an abscess in each tonsil, and such swelling as for a time almost blocked the throat. I believe that quinsy rarely begins simultaneously on the two sides, but that it rarely fails of being symmetrical in the end. One tonsil takes the start, and the other usually follows after a few days or a week. This was very definite in the case of my coachman, in whom I have just been studying the phenomena of the disease. He came to me first with a very hard swelling just above his left tonsil, and without the slightest affection of the other, and it was not until the first was on the point of breaking that the other tonsil followed in an exactly similar course. Acute and well-marked attacks of quinsy pass through definite stages, and subside completely after the abscess has given way or been opened, leaving no chronic disease behind. It is very important to seize the right time for incisions in quinsy. They ought not to be made until the abscess is ripe, and they then give wonderful relief to the patient.

No. LVI.—*A Rare form of Idosyncrasy.*

A curious and interesting example of idosyncrasy came under my notice in the person of Mr. A. P——, M.P. This gentleman told me that he had had many alarming attacks of sickness and pain in the abdomen, attended by swelling of the tongue and lips, and lividity of the face. On some occasions these attacks had been so severe as to cause great alarm to his friends. For long he had been quite baffled in his attempts to find out their cause. At one time he had suspected that it was fish-eating, and especially partaking of salmon. He found, however, that he could often take fish of all kinds with impunity. At length it became clear that it was parsley which did it. Subsequent experiments convinced Mr. P—— that the smallest fragment of parsley in any state, when fresh or dry, and whether in the form of sauce or otherwise, was adequate to produce an attack. He had of course ever since this discovery carefully avoided parsley. On one or two occasions, having taken it inadvertently in soup, his old symptoms had been produced. Mr. P——'s idosyncrasies did not end with parsley. He could not take the smallest quantity of honey, and certain kinds of fruit more especially always poisoned him. The symptoms resulting from these articles were similar to those from parsley, but not usually so severe.

No. LVII.—*Mr. Berry's Lectures on Bronchocele —Influence of Drinking-water, of Heredity, and of Sea-air.*

The researches as to the causes of Endemic Bronchocele, the results of which Mr. Berry recorded in his valuable lectures delivered a year ago at the College of Surgeons, have led him to the conclusion that the old theory is well founded which associated the disease with the use of drinking-water from certain special geological formations. From his own inquiries in the English area, and from those of Virchow in that of Switzerland, Mr. Berry thinks that it is shown to be highly probable that water derived from the magnesian limestone

is especially dangerous. He declines to believe that the air of mountain valleys has any influence in causing bronchocele, or that sea-air has any power in preventing it. He also refuses to accept hereditary transmission of tendency as an important factor, or even denies its influence.

I listened to Mr. Berry's lectures with great interest. They were the result of much original work and extensive investigation. I am bound to say, however, that I was not convinced on the last two points above mentioned. I still believe that bronchocele is hereditary, and that the air of the sea-coast is valuable both for prevention and cure. It is not sufficient to show (as Mr. Berry undoubtedly did) that cases may now and then occur at the seaside. Such are, I believe, very exceptional to the general rule.

#### No. LVIII.—*Benefits accruing from Erysipelas.*

My colleague, Dr. Warner, brought to me five years ago a lady with a tumour of doubtful nature in one breast. It was very definite, and my only doubt was whether it was adenoma or scirrhus. We decided to wait a month or two and watch it. Our patient went home, and not long afterwards suffered a severe attack of erysipelas, in which she very nearly lost her life. When she recovered the tumour was gone. I have attended this lady again for another ailment recently, and there is no sign of any return of her tumour.

An elderly surgeon consulted me on account of nasal polypi of some size, and high up in the nostril. They gave him great annoyance from obstruction, and we made an appointment for their removal. Meanwhile he fell ill with facial erysipelas, and had a severe illness. On his recovery he wrote to me in great delight that the obstruction in his nose had wholly disappeared. I believe that it never returned. He is not now living.

The benefits which accrue to lupus vulgaris from attacks of erysipelas are matters of general and frequent observation.

Brodie has the curious observation that syphilis will disappear upon an attack of erysipelas coming on.

It appears to me that facts such as the above favour to some

extent the creed that illnesses attended by fever and high temperatures may be prejudicial to the vitality of neoplasms and cause them to wither. The local effects of Koch's treatment, when good reaction was obtained, were not dissimilar from mild erysipelas, and it seems possible that their beneficial results may have been due simply to the febrile disturbance evoked.

No. LIX.—*Maternal impressions and family tendency to defects in development.*

Two sisters have each borne a son who has defective development of one hand. In one, the ulnar fingers are absent,\* and the middle and forefinger are webbed. In the other, the hand is absent by wrist-amputation in utero.

Both mothers are emotional, and highly educated; both attribute the occurrence to a maternal impression in early pregnancy. In one, a beggar showed his stump, and in the other, a man, who had had his fingers amputated, insisted on describing his operation and in showing his hand. No defects are known in other members of the family. It is, I need scarcely say, impossible that maternal impressions should produce such results. They are, no doubt, to be attributed to family inheritance, although their previous occurrence is not known.

No. LX.—*Variola as a cause of Blindness.*

The proportion of the blind in Ireland was, to the total population in 1851, one in 864, and in 1881, one in 847. Blindness was ascribed to smallpox in 725 cases in 1861, and only to 359 in 1881; a ratio to the total number of blind of one in 9·5 in 1851, and only one in 17 in 1881.

No. LXI.—*Estimation of Arsenic in the last century.*

Pomet,† in his "History of Drugs," 1748, says of the various compounds of arsenic then known, "All these kinds

\* Absence of the ulnar fingers is, I believe, exceedingly rare (see Vol. III., 304).

† He was chief druggist to Louis XIV.

are very powerful poisons and ought never to be thought of as internal medicines, though some have been so daring as to prescribe them " (p. 143).

No. LXII.—*Congenital Absence of Gall-bladder.*

In the Medical Transactions of the College of Physicians is the report of a case in which an infant lived five weeks having no gall-bladder and total obstruction of the ductus communis. The infant was jaundiced throughout, and had constant vomiting, white stools, deep-tinted urine. It died at last in convulsions.

No. LXIII.—*Associated Reflexes.*

"I cannot laugh without crying at the same time, and this makes other people laugh without crying."

A sea captain said this to me. He appeared to be in fairly good health, and there was no obvious explanation of this curiously exaggerated susceptibility of certain reflexes which are normally in some degree of association.

No. LXIV.—*On Diffuse and General Eczematous Dermatitis.*

In writing about the epidemic prevalence of diffuse eczema in workhouses, to which Dr. Savill and Dr. Lunn last summer drew attention, I have always contended that we had no new disease. The opinion which I expressed, as to the cases being examples of what is well known in the history of the senile forms of eczema, has received remarkable confirmation from the fact that several of Dr. Savill's last year's patients have returned to him again this summer with a recurrence of the malady. This is exactly in conformity with what we so often observe in the eczema of elderly persons. It is a disease which spreads by contagion, but which yet takes its origin, to a large extent, in the constitutional proclivities of the individual. Not a few of the workhouse cases of last year's epidemics had been sufferers from local eczema before.

The following narrative affords a remarkable illustration of

these statements. I have already published the case some years ago as an example of locally restricted dermatitis. I now give the sequel—an attack, after many years of local liability, of most acute general dermatitis. This final attack was exactly like the worst of the workhouse cases, and neither it nor they could be well separated from many others which have been allowed to rank as *pityriasis rubra*. Although I have previously published the portrait, yet for the reader's convenience I again give it.

I visited Mrs. L—— at her own house, and in consultation with Dr. Chitty, on Dec. 16, 1891. She was then suffering from a most severe outbreak of acute and universal dermatitis. It was of little more than a week's duration, but the epidermis was already peeling almost everywhere. The desquamation on her face and upper part of trunk was in thin small flakes, but on the extremities it was in large paper-like portions. On the hands it was stiff and coherent, like portions of a glove. The palms were denuded, but the digits were still covered by a detached shell which adhered only at their extremities. The nails were not as yet affected in any way, and were smooth and polished. The feet were affected in a similar manner to the hands, but not quite so severely. Everywhere the skin was of a vivid red, and in some places sore and cracked, but it was not weeping anywhere. Mrs. L—— had a dry tongue, and complained much of the general dryness of her mouth. Her pulse was sharp and somewhat hard, but her temperatures were normal.

I was told that the present attack was exactly like the one through which she had passed in 1888, and not more severe. I obtained from Dr. Chitty and herself a detailed account of the commencement of the attack. Before giving it, it may be well to state that during the last few years Mrs. L—— had been constantly using tar-wash for patches of *intertrigo*, &c., of which she had never been quite able to get rid. These had been present chiefly under the breasts, but she had always suffered constantly from more or less of *pityriasis* of the scalp. Whenever out of health, she had fissures occur at the corners of her mouth. Her hands and the skin generally, that is with the exceptions mentioned, had for long

been perfectly sound. She had enjoyed on the whole pretty good health, but had been indisposed to take exercise, and often out of spirits. She had not recognized any real threatenings of gout. During the two or three weeks immediately preceding the present outbreak, she had felt particularly dull and out of spirits, but had attributed it to the weather and time of year.

The onset of the attack was described as follows:—She was sitting in her room one evening feeling dull and miserable, when quite suddenly a chilly fit came on, and she shivered till her teeth chattered. At the same time her hands felt stiff and burning, and within a few hours they became red and swollen. She went to bed, and Dr. Chitty saw her the next morning. The rigor was on Tuesday, December 8th. On Wednesday her temperature was 103, and almost the whole surface of the body was involved in erythema. On Thursday the temperature was 101, on Friday 100, Saturday 99, and on Sunday normal. During the first few days there was acute œdema of the hands, wrists, and forearms, and some also of the feet. On Friday the dermatitis was at its height, and was absolutely universal. After this, desquamation began. At one time her appearance was as if she had been scalded all over. When the desquamation began her fingers became stiff, and as if cased in parchment. She complained that they felt as if they were in tight gloves. The appetite had been very bad, but there had been neither sickness nor diarrhœa.

Dr. Chitty told me that he had often examined Mrs. L——'s urine, but had found neither sugar, albumen, nor excess of uric acid. She was of gouty family and of gouty build herself, but had lived moderately.

During the six months which have elapsed since these notes were made, Mrs. L—— has gradually improved. She has been treated chiefly with opium and antimony. She is now well, with the exception of intertrigo.

## A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

### No. CXXXI.—*Traumatic Tetanus.*

#### QUESTIONS.

1. What circumstance in the history of a case is paramount in reference to the prognosis of Traumatic Tetanus?

2. What symptom ranks next to the history as affording aid in prognosis?

3. A young man of 20 received the charge of a shot-laden gun in the inner side of his thigh. A part of his cloth trousers was carried into the wound, and being firmly fixed the surgeon, although it protruded, did not think it wise to pull it out. The accident was on Dec. 28, 1838. A lotion and subsequently a poultice were used for the wound, and all went on well until Jan. 18, when locked jaw set in. There was trismus and opisthotonos. Venesection to syncope was practised, and five grains of calomel ordered immediately, with half a grain of tartarised antimony every four hours. Venesection was repeated on the 19th, 20th, 21st and 22nd. From the last date improvement was steady, and on Feb. 8 the surgeon in charge ceased his attendance, the lad being well. During the first five days the spasms had been very troublesome, but the pulse, although hard, had never been more than 80. In addition to the measures of treatment mentioned, purgatives had been repeatedly used.

Respecting this case the following questions arise: Was the surgeon justified in leaving a foreign body in the wound? (It remained one month.) Was a cold lotion the best application for a gun-shot wound? Was the vigorous treatment pursued suitable? Was the recovery fairly attributable to the treat-

ment? What features in the case might have justified, throughout, a favourable prognosis?

## ANSWERS.

1. The interval which has elapsed between the injury and the first symptoms of tetanus is the most important guide in prognosis. The longer the interval, the less severe the case.

2. The rapidity of the pulse is the chief symptom in estimating the probable severity of the case. If the pulse becomes rapid, almost from the beginning, the prospect is bad.

3. The surgeon ought certainly to have removed the foreign substance from the wound. It is even possible that the shot, wadding and portion of trousers left in the wound were the cause of the tetanus. As the wound was lacerated and contused, and must of necessity heal by granulation, the old-fashioned poultice would probably have been more appropriate than a cooling lotion. Inasmuch as the patient recovered, and as the free bleeding, &c., appeared to relieve symptoms and did not accelerate the pulse, it is impossible to censure the treatment as a whole. Since, however, there was an interval of three weeks between the injury and the first symptoms, and the patient's pulse was never more than 80, the prognosis was throughout favourable, and milder measures might have been attended with equally good results.

No. CXXXII.—*A Throat Case for Diagnosis.*

A healthy boy, two years and a half old, was admitted into hospital on account of loss of voice, hoarseness, and difficulty of breathing. He had no fever, and could at times sit up quietly and take his food without difficulty. He would even get out of bed and play about the ward. There was a history of an acute throat attack a year before for which leeches were used, since which there had always been some hoarseness but no difficulty of breathing. A week after his admission, there having occurred in the interval many attacks of most urgent suffocation, death from asphyxia occurred.\*

\* I have abstracted this case from a narrative by Dr. Hennis Green in the *Provincial Medical Journal*, 1842, but I have myself seen one exactly parallel with it.

## QUESTIONS.

1. What is the conjectural diagnosis of the disease ?
2. What means might have established the diagnosis ?
3. What ought to have been the treatment ?

## ANSWERS.

1. The persisting hoarseness and loss of voice indicated local changes, and opposed the suggestion of laryngismus stridulus. The absence of fever, the paroxysmal character of the dyspnœa, and the state of comfort in the intervals, made it certain that it was not an ordinary case of croup or diphtheria. Syphilitic affections of the larynx are almost unknown in children, and this child showed no signs of taint. There are well-known examples of papillary growths on the cords which occur in healthy children, and of these the case was probably an example. The history of a former inflammatory throat attack supports this conjecture.

2. The laryngoscope would have set the diagnosis at rest.

3. Tracheotomy was clearly indicated. After it had removed the danger of death from suffocation, treatment of the larynx might have been carried out.

[*Verification.*—At the autopsy, soft florid vegetations were found growing along the borders of the inferior chordæ. They projected into the ventricle and nearly filled it. The rima was extremely narrowed. The growths were covered by a tenacious mucus. There was no erosion or thickening of the mucous membrane of other parts of the larynx or trachea. The other organs of the body were healthy.]

No. CXXXIII.—*The Plague.*

1. What is the ratio of mortality from plague ?
2. To what circumstances do you ascribe our long-continued exemption from outbreaks in England ?

## ANSWERS.

1. Fifty per cent., but it varies with the severity of the epidemic and the part of it.

2. The disease spreads by contagion only, and the conditions which favour its contagion are fortunately excluded in the more developed civilization of modern times. It is probably never communicated through the air, but requires close

personal contact with the infected individual or article of dress. As a rule, repeated opportunities of contagion appear to be requisite. The modern home, with its roomy apartments and its free ventilation, and modern habits of dress implying frequent changes and great cleanliness, offer no facilities for the spread of such a disease. The enforcement of quarantine has also for some centuries prevented its introduction into England.

### No. CXXXIV.—*The Diagnosis of Acromegaly.*

1. A case has been recorded in which a man, aged 37, was affected with swelling of his hands, legs and feet, and with pains in his wrists and knees. His hands and feet attained the size which they had when he came under observation in the course of about three weeks. He was first seen on August 21st, 1888, and he died on October 28th of the same year. The whole duration of his illness was less than six months. At the autopsy, œdema and emphysema of the lungs were found, with, in each, a considerable growth of spindle-celled sarcoma. The liver was nutmeggy.\*

Is there any propriety in counting the above case as one of Acromegaly?

2. A man aged 54 died after a six months' illness which had commenced with stiffness in his legs and feet, and had soon been followed by enlargement of both hands and feet. He subsequently had epileptic convulsions, defective memory and delusions. The post mortem showed several cavities of different parts of the brain, a large causating mass in the lower lobe of the right lung, and a nutmeg liver.†

Is there any reason for claiming this case as one of Acromegaly?

3. A girl of nineteen complained of great weakness and swelling of the hands and feet, and of pain in the wrists, knees and ankles; she suffered from palpitation and shortness of breath, with severe pain in the right side. Within three months of the beginning of her symptoms she was confined

\* *Illustrated Medical News*, March 2, 1889.

† *British Medical Journal*, March 22, 1890.

to bed with inflammation of the lungs. Her knees, ankles and feet became considerably enlarged, but there was no alteration whatever in the bones of her face or skull.\*

What should be the diagnosis of such a case, and, especially, can it be claimed as allied to Acromegaly?

4. A Hindoo lad was the subject of great enlargement of his left foot. His second toe was immensely hypertrophied and the third considerably so; the other toes being all a little thickened. The foot had been enlarged as long as he could remember. There were supposed to be slight changes in the right foot and left hand, but these the patient himself scarcely recognized.

Were these changes those of Acromegaly?

#### ANSWERS.

1. This case would appear to have been one of general sub-acute rheumatism complicated by old disease of the liver and lungs, and by recent malignant growths in the latter. The whole duration of the case, and especially the rapidity with which the hands and feet had attained their increased dimensions, are quite conclusive against the diagnosis of Pierre Marie's malady.

2. This case seems to be one of hæmorrhagic apoplexy with chronic disease of liver and lungs, and with finally some rheumatic complications. The enlargement of the fingers was probably caused by the pulmonary obstruction, and belongs rather to the class of cases which Marie and Souza-Leite have named pulmonary osteo-arthritis than to true acromegaly. The whole duration of the case is much too short for the latter malady.

3. This case appears clearly to be one beginning with pleurisy and pneumonia, and complicated with rheumatism. Probably pulmonary obstruction to the return of venous blood had much to do with the enlargement of the fingers, but as there was considerable effusion into the knee joints it is clear that rheumatoid arthritis must be accepted as taking also a large share. As the hands and feet attained their in-

\* Transactions of Royal Academy of Medicine of Ireland, vol. ix, p. 64.

crease of size in "a few weeks," it is certain that the case had no real affinity with acromegaly.

4. The non-symmetry and the congenital, or, at any rate, infantile, origin of the changes are conclusive facts against the diagnosis suggested. It was probably an example of congenital pes gigas.

#### No. CXXXV.—*Niebuhr's Illness.*

Niebuhr, the great Danish historian of Rome, died on Jan. 2, 1831, at the age of 55. He had taken a chill in coming home from a news-room where he had been eagerly studying the trial of the ministers of Charles X. The evening was very cold. His illness was of only a few days duration.

#### QUESTIONS.

1. How ought the expression "taken a chill" to be translated into medical language?
2. Of what did Niebuhr probably die?
3. Niebuhr had suffered from malaria in his childhood. Is it probable that this had anything to do with his fatal illness?

#### ANSWERS.

1. Taking a chill implies a reflex disturbance of the nervous system productive of rigor and attended by congestion and consequent inflammation of some surface or viscus.
2. The cause of death was probably catarrhal pneumonia.
3. The previous occurrence of ague exercises an influence over the patient's nervous system which lasts the rest of the patient's life and gives a special tendency to the occurrence of rigors. It may have increased the injurious influence of the chill. Catarrhal pneumonia is, however, a very common cause of death, quite independently of malaria.

#### No. CXXXVI.—*On Croup and Diphtheria.*

#### A CONVERSATION.

*Ille.* I infer from what you have said that you do not see any real distinction between diphtheria and croup.

*Ego.* Croup is sporadic diphtheria, and diphtheria is croup become contagious and spreading as an epidemic.

*I.* Then you think that croup may begin independently of contagion?

*E.* Most certainly. Sporadic cases of what is called "true croup" begin probably as catarrhal pharyngitis.

*I.* Then you hold that a malady which takes origin in the causes of ordinary catarrh may become contagious?

*E.* Undoubtedly. All catarrhs are contagious, and for the matter of that, almost all forms of inflammatory action are productive of elements capable of causing contagion.

*I.* Diphtheria is now usually placed amongst the specific fevers. Do you doubt the correctness of such position?

*E.* I do most definitely. I should place it in a group of which erysipelas is the type, and in which a local inflammation precedes and causes the fever. With it I should place phagedæna, cancrum oris, carbuncle and a few others. Eczema when it prevails epidemically, that is when it becomes contagious as recently seen in the London Workhouse Infirmaries, must also be so classed.

*I.* But the diseases you have named do not usually prevail as epidemics.

*E.* No, not often, but they do occasionally. We have had terrible epidemics of hospital phagedæna, just as we have recently had of hospital eczema. So also of erysipelas. Its cases are usually single, but when the conditions favour, it may become epidemic. This is the general law of contagious inflammations. They do not usually seem to spread readily, but when once they have become epidemic they may show great virulence.

*I.* Do we ever witness epidemics of erysipelas from contagion?

*E.* Yes, and unfortunately medical men are usually the means of spreading them. It is more especially when erysipelas has been transmuted into puerperal fever that we witness its virulence as a contagious malady. Surgeons to large hospitals, however, know more than enough of it in its original type as an inflammation affecting wounds. The present generation of surgeons know little or nothing either of epidemic erysipelas or of epidemic phagedæna, but their predecessors knew them only too well.

*I.* You believe, then, that erysipelas and hospital phagedæna may originate spontaneously, and may also become contagious?

*E.* I do. Given the conditions, that is plenty of susceptible persons, and close and continuous intercourse, and they are sure to spread.

*I.* You speak as if what you term the transmutation of erysipelas into puerperal fever were an acknowledged fact. Is that so?

*E.* It ought to be. The classic narrative of his own experience by the late Mr. Storrs, of Doncaster, supported as it is unfortunately by much that has since accrued, ought to be held conclusive. Puerperal fever, or puerperal metropéritonitis, is in most instances another name for erysipelalous infection of the placental detachment-wound. During last summer I was made acquainted with the death from "puerperal fever" of a young married woman. I knew also that there had been in the same village a case of fatal erysipelas after a compound fracture of the leg. I found, on cautious inquiry, that the same surgeon was attending these two patients at the same time, and further that the same nurse was transferred from the one case to the other. I have known not a few such coincidences, and during my student life a lamentable and most conclusive piece of experience occurred to myself.

*I.* But admitting, as all must, that erysipelas may become contagious, are you not assuming what is not probable when you suggest that it ever originates in any other way? Is it ever of spontaneous (so to speak) origin?

*E.* I take it as exceedingly probable that facial erysipelas may and does often take its origin in exposure to cold wind. Those who have had it once are very prone to have it again. You may say that facial erysipelas is a different disease from erysipelas as we find it attacking wounds. I should be very sorry to expose an operation case to the risk of contagion from the facial disease. Also as regards the traumatic form, it occurs very frequently under conditions which make contagion very improbable. If it always depends upon the introduction of parasitic germs, those germs must be ubiquitous,

and they must also be capable of resting dormant in the organism for long series of years. The patient who has had erysipelas after an operation will very probably have it again after another, even with a ten or twenty years' interval.

*I.* You do not, then, regard erysipelas as a specific fever?

*E.* No, indeed. We know nothing of specific fevers of which one attack renders a patient more prone to another. I regard erysipelas as a fairly well specialized type of inflammation which affects lymphatic spaces and which causes fever, but the local process always precedes the fever, not the reverse. Erysipelas observes no definite stages, is of very variable duration and severity, and above all may often be cured most definitely by local means. It is, besides, never symmetrical, but begins locally, and spreads from its place of origin by continuous contagion. It has no analogies with such maladies as measles, smallpox, and syphilis.

*I.* Do you, then, consider erysipelas as catarrhal?

*E.* No, not if we are to use our words with precision. I do not believe that a patient would ever get erysipelas of the face from having his feet wet or from exposure of his back to a draught of cold air. It requires some special damage to the part itself, whether from wound, from irritants, or from the direct influence of cold. Catarrhal inflammations are reflex in their mode of production; erysipelatous ones are local.

*I.* I observed that you mentioned carbuncle with phagedæna and erysipelas. Is it not rather a grouping of dissimilars?

*E.* I do not think so. A carbuncle is a boil with a tendency to spread at its edges. The spreading is effected by contagion along continuous tissues just as in erysipelas. In truth, the spreading of a carbuncle is by no means wholly dissimilar from that of phlegmonous erysipelas. The same brawny induration and solid œdema attends them both. In both, the amount of disturbance of health and of danger to the patient are in ratio with the extension of the local disease. Both may be cut short at any stage of progress by suitable local measures.

*I.* To return to our first subject, may I ask if what you

assert as to there being no real difference between croup and diphtheria is generally acknowledged?

*E.* Professional opinion is in an uncertain state. My impression is that a large majority now make no distinction, and I am sure that those who do so find themselves involved in inextricable difficulties. The two words still occur in most of our statistical list of diseases, and a few cases are still ranked under that of croup. The late Dr. Semple, who translated for the New Sydenham Society the French Memoirs on Diphtheria, became so impressed with the identity, that he used to beg his friends to find him an example of croup. Dr. Afleck, in the "Encyclopædia Britannica," perhaps the latest expression of opinion, holds that they are different, but does not attempt to establish any diagnosis.

*I.* But is it not still true that cases of inflammation of the larynx and trachea, with the formation of false membrane, are met with in healthy children who have not been exposed to contagion, and from whom no contagion is seen to spread?

*E.* I have not the least doubt of it. They are what I would call spontaneous or catarrhal cases.

*I.* Why not call them Croup, in distinction from the epidemic form?

*E.* I would give them that name, but I would give it also to the other cases. I hold that such cases may become the parents of epidemics.

*I.* Perhaps you prefer the name croup for both?

*E.* I do. Brettoneau made, so far as I understand the subject, a serious mistake when he thought that he had discovered that diphtheritis is "not an inflammation but a fever," and named it diphtheria. We must now go back on the old lines. The Germans already use the adjectives croupous, croupal, &c., as applicable to all inflammations of mucous surfaces attended by membranous formation. If we continue the use of the term diphtheria, it must be understood much in the German sense.

*I.* Still, however, is it not the fact that there is something very peculiar in the debility which attends all true diphtheria, and does not this tendency to exhaustion make the diagnosis between it and other inflammations of the throat?

*E.* By no means. Men who observe diphtheria only as it is seen in consultation practice or in hospitals, form very exaggerated impressions on this head. Severe cases of diphtheritic throat are undoubtedly attended by great exhaustion, and in some cases the debility may appear to be disproportionate to the local affection. Those who, however, in family practice have opportunities for observing the disease as it occurs in epidemics, will tell us that a great many patients have it very mildly and show no special debility. In many it is simply a matter of a few days' sore throat and nothing more.

*I.* How do you explain the debility which is so strongly insisted on by all who have described the malady?

*E.* It is probably in part due to blood poisoning and nerve irritation from the local inflammation, but in perhaps a yet larger part it is the result simply of starvation. A malady which interferes with respiration and almost wholly prevents deglutition, is likely, especially in young subjects, to be rapidly productive of exhaustion.

*I.* Do you regard the production of membranes as essential to the diagnosis of diphtheria or croup?

*E.* By no means. The free production of membranes or casts depends upon the proclivities of the individual patient. Age, for instance, may influence it. Old persons but rarely form membranes freely. During epidemics of croup, different cases vary exceedingly as regards the abundance of membranous effusion, and a certain number of even fatal cases are always witnessed in which no membrane whatever is found. Diphtheritis, or pellicular inflammation, although a common and conspicuous feature in most cases of diphtheria or croup, is not an essential. What is known as diphtheritic ophthalmia, for instance, is usually attended by infiltration only, and shows no membrane.

*I.* If, then, you deny that membranous effusion is pathognomonic, how about the subsequent paralysis? Is that characteristic?

*E.* There is, I admit, something very difficult to understand in the association of paralysis with diphtheria. I do not, however, in the least believe that the explanation is to be

found in the hypothesis that diphtheria is a fever. As a rule, the occurrence of paralysis after a sore throat may be held to imply that the latter was of the diphtheritic class (including, of course, croup), but it is not conclusive. I have seen paralytic loss of accommodation after other forms of sore throat, and I am inclined to associate it rather with the part affected than with anything specific in the malady. We must remember that paralysis is a rare and quite exceptional occurrence even in diphtheria epidemics.

*I.* I understand you to deny that there is anything peculiar in the debility which attends diphtheria, to assert that the production of membranes is not essential, and that even the subsequent occurrence of paralysis cannot be held to be pathognomonic. I do not see how the differential diagnosis of diphtheria from other forms of sore throat is to be made.

*E.* That is precisely the conclusion to which I wished to lead you. We must not attempt arbitrary definitions, and the search for pathognomonic symptoms is one which is very likely to lead us into serious clinical error. The simple fact is that you cannot by a single symptom, nor by any group of symptoms, distinguish croup from diphtheria, or either or both of them from catarrhal sore throat or from hospital sore throat. It is absurd to allow the severity of the case to become an element in its diagnosis. Infantile laryngitis may at any time run on into the most typical croup; in fact the latter is usually preceded by a stage which takes rank under the former name. The difference is one mainly of degree of severity. It is the same with hospital sore throat and the patchy tonsil; you cannot diagnose them from diphtheria, because they are simply its minor forms.

*I.* Still, I suppose we must make a difference between those cases of diphtheria originating from contagion and those which you would suggest begin from catching cold?

*E.* There you touch the pith of the argument. Undoubtedly you must. Although I firmly believe that the one may be in a sense the parent of the other, yet they are different. The croup or diphtheria which takes its origin in catarrhs, is more gradual in development than that which results from contagion. When a virus has been bred up to

contagious virulence, it stamps a kind of specificity on the epidemic induced. No two epidemics of contagious croup are exactly alike. Some are much more severe than others. It is also a matter of common observation that the contagion seems to decline in virulence when the epidemic is protracted, and the later cases are less severe than the earlier ones.

*I.* This, it appears to me, is precisely the law which is so well recognized in reference to the specific fevers, yet you deny that diphtheria is one of them.

*E.* Quite true; but there is nothing improbable in the suggestion that the law may apply to poisons which still are not absolutely of the same class. No one can doubt that there is a well specialized form of contagion afloat during an epidemic of diphtheria, just as during one of measles; but it is matter for observation to decide whether in the one or other case the contagion may take origin *de novo*. In the case of measles, observation seems to show that it cannot; whilst in the instances of common catarrh, diphtheria, erysipelas, and many others, it seems to indicate that it may.

*I.* In using such an expression as "origin *de novo*" in connection with "a well specialized form of contagion," are you not perilously near the hated doctrine of spontaneous generation?

*E.* We must not be frightened by bugbears.

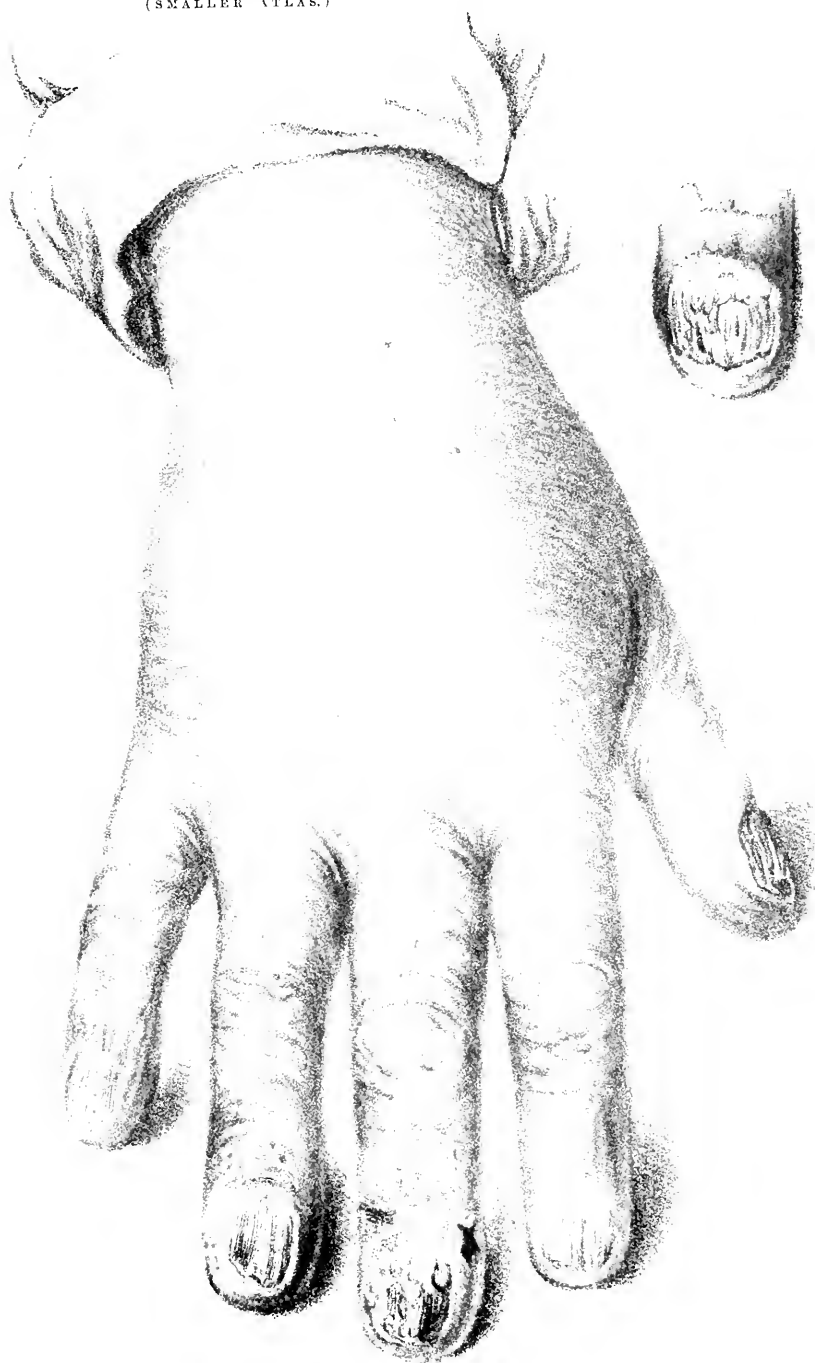


## PLATE L.

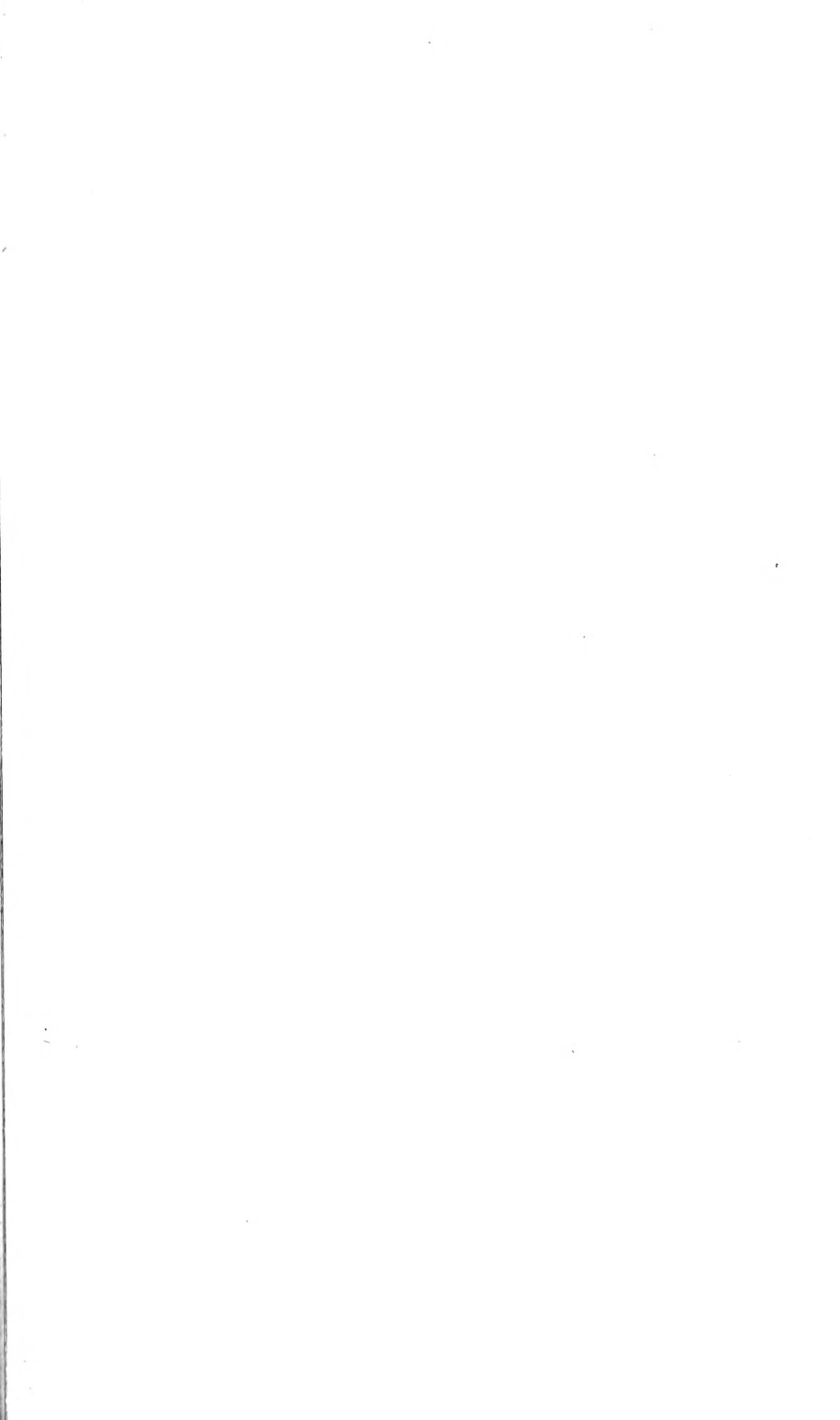
### ACRO-DERMATITIS WITH DISEASE OF THE NAILS.



THE hand of an old man who suffered from acro-dermatitis with chronic disease of his nails. His case is fully described at page 251, Vol. II. He was a man originally in vigorous health, and in childhood had never suffered from chilblains. At the age of 32, that is, forty years before this sketch was taken, he had suffered severely from chilblains. During the last ten years, as an amateur gardener, he had exposed his hands a good deal to cold. A few days of frosty weather were, he said, always sufficient to make his nails brittle, and his finger-ends sore. I have little doubt that both the chronic eczema and the disease of the nails were attributable to the influence of cold upon a patient whose circulation, originally vigorous, was enfeebled by age, and by the previous occurrence of frost-bite. They must rank, therefore, as a form of acro-dermatitis in definite alliance with Raynaud's phenomena.







## PLATE LI.

### CHILBLAIN-LUPUS OF HANDS.



THIS portrait shows the condition of the hands in the case of a young woman who was the subject of lupus on one cheek, and of ulcerations of the ear. The conditions exhibited may perhaps be ranked as a peculiar form of chilblains. They are met with in association with certain special types of the lupus process, and with feebleness of the circulation. It will be seen that there are numerous pits which have been left by the healing of ulcers, and other little patches where the skin has become white and gangrenous. A portrait showing the condition of the face of the same patient is given in Vol. I., Plate X., and both may be profitably compared with Plates VI. and VII. in Vol. I., which illustrate the case of Philip Holmes; also with Plate VIII. in Vol. I., illustrating lupus erythematosus. These conditions are generally worse in winter and cold weather, but sometimes appear to be almost independent of season.





# ARCHIVES OF SURGERY.

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OCTOBER, 1892.

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## ON THE MEDICINAL USES OF ARSENIC.

ONE of the many excellent efforts in the direction of Collective Investigation undertaken by the British Medical Association was that made in the year 1846 as to the medicinal action of arsenic. Its results were summarized by Mr. Thomas Hunt, in the Transactions of the Association for 1849 (see page 383). This Report had, I believe, a not inconsiderable effect in removing prejudice (which was then strong) and in confirming the confidence which not a few in the profession were already beginning to entertain in this remarkable remedy.\*

As the Report in question is probably not accessible to many of my readers, I shall venture to commence my present paper by a statement of some of its principal points.

All of those who reported concurred in the statement that they had never witnessed fatal results from the medicinal use of arsenic, and most said that they had never seen any serious detriment to health. A case is related (by Mr. Girdwood, page 404) in which by mistake a patient took during twenty-four hours two drachms of Fowler's Solution, and was cured by it of an ague without injury.

\* One reporter actually forbids Dr. Hunt to mention his name. He writes: "I regard it as invaluable. I would sacrifice nine-tenths of the materia medica for arsenic. This, however, I state *privately*, for the prejudice against it is very strong, and I have neither time nor inclination to become its champion." Mr. Hunt speaks of the writer as one "whose experience in arsenic is, I believe, far greater than my own."

The Report affords a certain amount of evidence in favour of the belief that those who take much exercise in the open air may bear well double or treble the dose which would be suited for those of sedentary occupations.

It is generally agreed that a dose of eight to ten minims of Fowler's Solution three times a day is a full one, and ought but rarely to be exceeded. Much smaller ones had been employed by most of the observers.

It is noted that children usually take arsenic well, but I find no reference to the converse fact, with which I have myself been impressed, that with elderly persons the drug often disagrees.

There is a fairly general agreement that arsenic should not be given during the acutely inflammatory stage of skin diseases. There is, however, no reference to its specific powers over pemphigus, in which malady we now invariably prescribe it without any reference to stage.

There is a marked discrepancy in the observations as to whether arsenic should be regarded as a tonic or depressant. This Mr. Hunt endeavours to explain by suggesting that it is primarily a tonic and secondarily depresses. I may venture to suggest, however, that differences in dose have probably more to do with it.

As regards the special preparation used, there does not appear, from the replies given, any reason to believe that where the effects of arsenic are wanted, any better or safer salt can be used than Fowler's Solution. Here again we encounter the important question of dose. It does not follow that because you may give with impunity double the quantity of some other salt, that therefore the latter is really safer. What is required is effect, and the remedy which attains a certain end in three minim doses may be just as safe and useful as another of which you may give twelve with impunity. Dr. George Webster writes of De Valangin's Mineral Solvent (a hydrochlorate of arsenic) that you may give much larger doses, and that it is milder in its effects. Such statements need to be carefully tested before we accept them as of any real clinical importance.

There is no reference to the production of Herpes zoster

by arsenic, nor any to the now well-recognized result of a brown or earthy discoloration of the skin. Nor have we any suggestion that the drug may occasionally cause multiple neuritis, epilepsy, or paraplegia. Of the corneous condition of the palms and soles which occasionally passes into cancer we have no mention.

The occasional production of vesicles upon the soles of the feet (a symptom which some modern dermatologists appear to have forgotten) is, however, referred to in the following terms by Dr. Theophilus Thompson, and the observation is confirmed by Mr. Hunt:—"A gentleman to whom I had given Fowler's Solution for three months persevered with eight-minim doses after stiffness of the eyelids and nausea had occurred. Violent vomitings followed perspirations and copious discharge of urine which appeared to contain blood. In this instance some vesicles appeared on the feet (an appearance which I have somewhere seen mentioned as an occasional effect of arsenic)." Mr. Hunt adds: "The vesicles on the soles of the feet I have recently noticed in three different cases."

The conditions noted as indicative of disagreement are the following:—"Conjunctivitis," "swelling of the limbs and features," "irritation of mucous membranes," "purging," "gastritis," "desquamation of cuticle," "general inflammatory state," and "flushings." More specially connected with the nervous system are "headache," exhaustion, restless nights, sinking, giddiness, palpitation, and mental agitation and alarm.

The Report is, as a whole, very creditable to the zeal and fairness of Mr. Hunt, who was, as is well known, a warm advocate for the use of the drug. Mr. Hunt speaks with modesty of his own experience, and criticises the statements of others with much judgment. He urges with propriety the necessity of attention to his own well-known rules to begin with a full dose and reduce it on disagreement being manifest, to give it on a full stomach, not to use larger doses than from eight to ten drops of Fowler's Solution, and usually to be content with smaller ones.

Much of the Report deals with the use of arsenic against

ague, neuralgia, and allied maladies, and in this direction most confident opinions are expressed. One observer, Dr. William Dix, practising in a fen district, speaks of using "fifteen wine quarts of Fowler's Solution" in the year. Concerning this employment of the drug, we have fortunately of late years had much less experience, since malaria in its more severe form is almost unknown.

I will now take leave of this valuable Report and proceed to the record of some cases and observations of my own. Before doing so, I may mention that I published three years ago a Lecture on Arsenic, in which many of the points which I now purpose to discuss were referred to.

We shall probably place ourselves in the best position to understand the effects of arsenic, if we assume that, for the most part, it acts directly upon the cell elements with which it comes in contact. We may suitably avoid altogether hypotheses of reflex or "sympathetic" irritation and of influence on the blood-vessels. Being easily soluble, it is probably susceptible of almost infinite dilution, and being carried by the blood into contact with all the tissues, it probably affects their state by direct imbibition.\*

If we accept this as a basis of our inquiry, we have next to investigate as to which tissues show the greatest tendency to suffer. This is a question solely for clinical experience. It is a matter of all but universal experience, in reference to the lower forms of organic life, whether vegetable or animal, that arsenic tends to retard cell-growth and to destroy life. With the very rarest exceptions all cryptogamic forms submit at once to its influence.

We need not discuss the question as to whether arsenic should rank as a tonic or otherwise. It is extremely probable, *a priori*, that it would produce results apparently very different in different states. We might expect it on the hypothesis suggested to control processes of inflammation

\* In reference to this hypothesis we need not place too high a value upon the negative fact that chemists have encountered great difficulty in detecting arsenic in the blood and soft tissues. The quantity present is probably exceedingly minute.

attended by cell-proliferation, since it represses cell-growth in general. In this way its influence over such a disease as psoriasis may be taken as explained. It is upon this power that the recommendation of its use in cases of cancer and new growth in general are based. Just, however, as it tends to repress excess of cell-growth when this exists as a disease, so by precisely the same action may it so degrade the vital activity of a healthy tissue as to cause it to take on disease.

Thus in some cases it may seem to clear the complexion, as in cases of acne, when it causes disappearance of pustules; whilst in others, if pushed, it may induce a muddy and dirty state of skin by lowering nutrition and favouring epidermic exfoliation.

I do not know of any examples of skin disease, produced by it, in which the changes assume the form of overgrowth. Such are common in the instance of iodide of potassium, but (if we except the exceedingly rare occurrence of "arsenic-cancer") they are unknown in that of arsenic.

It is highly probable that it may cause neuritis, but we have not as yet any demonstration as to what special parts of the nervous system it can throw into inflammatory disturbance. We do not know whether, for instance, it influences the primary nerve-cells themselves, or the nerve-tubules, or the areolar elements by which they are surrounded. We know clinically, and beyond the slightest shadow of doubt, that it can produce that form of nerve-disturbance—probably a neuritis—which results in Herpes Zoster. And we know that it can cause numbness, loss of sensation, and muscular debility in varying degrees of severity. The Herpes which it causes is always non-symmetrical; but the motor and sensory forms of paralysis are only exceptionally so. These exceptions are, however, quite sufficiently numerous to give strong support to the belief that the action of the drug is direct and local. Some facts favour the belief that the terminal parts of the extremities are usually first affected, though by no means invariably so. It is exceedingly rare to meet with any form of paralysis affecting the trunk, the head, or the sphincters.

Dr. Graves cites Orfila as an authority for the fact that arsenic given to dogs causes paraplegia of the hinder extremities. These were cases in which large doses were given. Periera does not mention paralysis amongst the results of arsenical poisoning.

Dr. Faulkner, in the *Memoirs of the London Medical Society*, vol. ii., has stated that he had repeatedly witnessed local paralysis as a consequence of arsenical poisoning. He alludes to one case in which the hands only were paralysed, and to two others in which the palsy spread gradually upwards from the fingers till the whole arms were affected.

In another case, published by Professor Bernt and quoted by Christison, after an overdose of the arseniate of potash, the patient lost sensation and the power of motion in the hands, and lost motion in the feet. In this instance there was contraction of the knee joints.

Dr. Murray, of Alford, has recorded in the *Edinburgh Medical Journal*, vol. xviii. p. 167, a case in which four persons were simultaneously poisoned by arsenic. In all the muscular debility was very great. One of them lost altogether the use of the muscles of the left arm, and six months later continued to be unable to bend the arm at the elbow joint. We may note here that the paralysis was unsymmetrical. In one of the other patients there was great general debility and long-continued numbness and pains in the legs.

It would appear that in most cases of arsenical paralysis, recovery, although long delayed, finally ensues. Dr. Christison, however, quotes from the *German Ephemerides* the case of a cook who had paralysis of all her limbs after acute arsenical poisoning, and in whom, although she lived for many years, the condition never disappeared.

A case is related by Dehan in which a woman who had taken by mistake a small quantity of arsenic began to suffer on the fourth day from cramps, tenderness, and weakness in all the extremities. The symptoms increased, until the whole extremities became almost completely paralysed. At the same time the epidermis desquamated. The power of motion returned first in the hands and then in the arms. She had a long illness, was in the hospital eleven months, but eventually recovered.

*Case illustrating the influence of Arsenic in causing changes in the nutrition of the palms and soles, with tendency to epithelial cancer (Arsenic-Keratosis and Arsenic-Cancer).*

I published some years ago some very important cases in which it was believed that the long-continued administration of arsenic in full doses had induced changes in the nutrition of the skin of the palms and soles.\* These changes had ob-

\* I am indebted to Dr. Colcott Fox for a reference to a statement by Sir Erasmus Wilson on this subject (*Lectures on Dermat.*, 1873). It is to the effect that arsenic may produce not only desquamation of hands and soles of feet, but also thickening of epidermis to a considerable degree from hyper-nutrition, and may occasion the formation of minute granular corns, each little corn corresponding with the aperture of a sudoriferous duct.

served several stages. First, a peculiar dryness and burning of the part; then the production of little corneous indurations; and finally, in three instances, the development of epithelial cancer of a peculiar type. To the latter I ventured to give the name of Arsenic-Cancer. Since these observations were made I have had many opportunities for, in part, confirming them, and they have also been confirmed, in part, by many other surgeons. Thus it is, I think, now generally admitted that arsenic may cause the skin of the palms to crack and become dry, and that it may develop little corn-like epidermic indurations. I am not aware, however, that any new observations have been recorded bearing upon the statement that as a final stage these corns may end in epithelial cancer. Nor have I had myself, during the six years which have passed, any case which I could claim as an example of "arsenic-cancer." Within the last few weeks, however, I have been consulted by a gentleman whose case most remarkably supports the views to which I refer. He is now a man of 40, and in good general health. Five years ago, being the subject of an abdominal tumour, which was believed to be a sarcoma and was rapidly growing, he was advised to take arsenic. As the drug appeared to him to diminish the growth of the tumour, and to greatly benefit his health, he did not keep to the dose which had been prescribed. He often took from half a drachm to a drachm a day of Fowler's Solution, and he continued this for two years at least. The only inconvenience which the drug produced was occasional purgation, and as this appeared to relieve his abdominal symptoms, and in particular to reduce the ascites from which he suffered, he persevered in the use of the large doses, without obtaining further medical advice. At length he began to be annoyed by great sweating of the palms and soles, and next the epidermis began to thicken in patches, and to form corns. The arsenic was continued in reduced doses for a year longer, when, the state of his hands and feet becoming more and more troublesome, and appearing to be distinctly attributable to it, it was almost wholly laid aside. When I saw him it was four years from the commencement of the arsenic, and a year after its almost total disuse. The changes in the nutrition of the palms and soles had gone on

slightly increasing rather than otherwise, during the year in which the arsenic had been disused. The palms of the hands and the palmar aspects and sides of the fingers were covered with hard corns, from the centres of many of which the epidermis was breaking up in flakes. In some places, by the confluence of these corns, ridges had been produced. On the soles of the feet there were similar conditions, which advanced, especially in the region of the heels, up their sides. In more than one position there was a tendency to papillary growth, which could not but cause anxiety as to its being an early stage of cancer.

*Life-long use of Arsenic—Epilepsy—Arsenical Eczema (Herpes)*  
—*Temporary Diabetes and Albumenuria.*

In the case which I have next to relate we have an illustration of the almost life-long use of arsenic. It is many years since the patient was under my observation; he has, indeed, now been dead for at least ten. Sir George J. was a gentleman of high eminence in the legal profession. He was about 60 when I knew him, and had taken arsenic almost from boyhood, with interruptions, but never leaving it off for a whole year. His complaint was a peculiar form of psoriasis. Arsenic had often cured this skin disease, and had always shown a remarkable degree of power over it. No other drugs had, I was assured, ever done it the least good. Sir George had been under the care of most of the London dermatologists of his day, and under several Continental ones, he had also formerly been a patient of Sir Benjamin Brodie, Dr. Copland, Dr. Prout, and others. Possessing a highly-trained mind, he gave me his evidence in a most lucid manner. When he consulted me he was apparently in vigorous health in all respects, but his psoriasis still troubled him. This eruption had begun, he said, at the age of 17, and Sir Benjamin Brodie then placed him under the treatment of the late Dr. Gaskoin, who administered arsenic in full doses. As the result, as he believed, of the drug, an epileptic seizure occurred.\* This fit was

\* A case in which epilepsy occurred in connection with arsenical poisoning is recorded by Dr. Rougart. "A girl swallowed a drachm of white arsenic, and soon experienced the usual symptoms of violent intestinal irritation. At the end of

never repeated, but it was because he had several times since, when taking full doses, experienced sensations in his head which led him to think that he was going to have another fit, that he was convinced that the first, and only one, was caused by it. Some time later, and again when under the influence of arsenic, he had a fainting attack. Many years after this he suffered much from pain in the top of the head—"a creeping" and sometimes "a twisting feeling" in the middle of the top of the head. He consulted several physicians for this, and some suspected that he had organic disease. It finally, after some months, disappeared when he left off the arsenic.

On several occasions, as a definite result of arsenic, he had suffered from extreme irritability of bladder, so that he was obliged to pass water every half hour, and could not retain it for a minute after the desire had commenced. He believed that on these occasions the kidneys were stimulated as well, and that the quantity was much increased. This symptom always disappeared when he left off the drug. I have seen several other cases in which exactly the same symptom was experienced. In one of them it was attended by great reduction of the virile function, but this never happened in any degree whatever in our present case. Sir George was quite familiar with what he called "Arsenical eczema," but did not appear to have ever had herpes zoster. Of the eczema he had had many attacks, and he gave me the following facts respecting it. It will be seen that it had differed very much from true eczema. The eruption usually occurred in large patches on the thigh, arm, or trunk, oftenest on the thigh. These patches, sometimes as large as the two outspread hands, usually first appeared as groups of small red spots, which rapidly became vesicular, and then soon dried up. The eruption never lasted

twenty-four hours these had somewhat subsided, but after another day she began to complain of coldness in the spine, giddiness, intolerance of light, and fainting. She had also aching of the extremities and tingling of the whole skin. At the end of the sixth day she had an attack of left-side convulsions, with foaming at the mouth, with total insensibility; the attack lasted two hours, the insensibility remaining through the night. A succession of similar but slighter attacks occurred during the next fortnight. But eventually she was restored to health."

—*Medical Chirurgical Transactions*, vol. ii. p. 134.

more than three or four days, and within a week it was usually quite well. He did not remember that the patches had ever occurred symmetrically, and as a rule only one had been present at once. In these features of spontaneous curability and of non-symmetry we may note that it conformed much more closely to the character of herpes than that of eczema.

Of the more ordinary symptoms of arsenical disagreement, —red eyes, irritable stomach, palpitation or debility,—Sir George had never had the least. Sometimes he had experienced some abdominal pain, attended by slight tendency to diarrhœa, but never amounting to colic.

A very curious, and to me wholly new result of arsenic-taking had been noticed on two occasions, namely the production of temporary diabetes. On one occasion Dr. (now Sir) George Johnson found sugar present in considerable quantity, and on another, although no analysis was made, the evidence is conclusive, for the urine doubled in quantity and in specific gravity at the same time. On both occasions the diabetes was only temporary, and ceased soon after the arsenic was stopped. On another occasion the urine for a short time contained much albumen. Many times the quantity of urine had been greatly increased, and it is quite possible that in some of these also sugar may have been present. No numbness of the feet or hands had ever occurred.

Sir George had often tried to do without arsenic, but had never found that he could keep down his skin disease by any other treatment. He had often taken four months' courses, and he believed that he had usually had full doses. The exact doses which he had used he did not know.

Although such varied and definite maladies had at different times been produced by the arsenic, yet we cannot allege that on the whole it had interfered with the health. On the contrary, he had maintained, partly perhaps by its aid, a condition of unusual vigour in all respects. He was married, and the father of several children. He was moderately stout, and rather florid.

If we hold the proof deficient that the arsenic caused either the epileptic attack or the fainting fit or the long-continued pain in the head, for all these may possibly have been due to

other causes, we still have in the other symptoms a series of important phenomena, respecting the cause of which no doubt can be felt. I have therefore thought the case worthy of being recorded in detail. It is one to which I have on several former occasions briefly alluded.

*Case showing the influence of Arsenic upon the Nutrition of the Extremities—Psoriasis leaving Stains—Very definite cure of the Eruption by the Drug.*

A chemist's assistant applied to me for advice as to his skin. As he appeared to be a very intelligent man I took the opportunity of recording his experience as to treatment. He told me that he had had psoriasis from boyhood, and that one of his sisters suffered also. It had not given him much trouble until of late years. He had taken arsenic several times, and twice in what he called "regular courses in large doses," that is, gradually increasing doses up to ten minims three times a day. When pushed in this manner it always acted, he said, very definitely. On one occasion it had made the skin of his hands peel, so as to almost disable him from his occupation. This occurred quite early in the course, and did not persist very long. The backs of the hands were more affected than the front. He remembered that at the time of the peeling his hands used to tingle and burn.

At the time that he came to me he was absolutely well of his psoriasis. He came because some stains had been left where the patches had been. He was anxious about these because he fancied they implied some syphilitic taint. For this suspicion there was no foundation whatever, for he had never had syphilis. His skin was supple and soft and quite free from scales, but in all parts where the patches of psoriasis had been it showed a deep brown tint, which marked their areas quite abruptly. The patches were in their usual positions on arms, back, and limbs, and many of them as large as an outspread hand. He was a man of very dark complexion, black hair, and very swarthy skin. I assured him that the pigmentation of the patches was due chiefly to his complexion, and to the large quantity of movable pigment in his system, and not to syphilis or any peculiarity in his eruption. At the same

time it was quite possible that the general pigmentation of skin was partly due to the arsenic.

As he was well experienced in drugs I asked him if he had not tried the effect of chrysophanic acid. He said that he always used it for the scalp and face, but never for his body on account of the inconvenience. The large doses of arsenic had, he said, never disagreed with him, and he had established his cure by continuing them some time after the eruption had disappeared. He had only left them off about two months when I saw him, and was then in excellent health.

*(To be concluded.)*

## NOTES ON THE USE OF MERCURY.

On many subjects, and especially those in which therapeutics are concerned, we may recur with interest and profit to the detailed writings of our predecessors. They used most of their drugs with a freer hand than we do, although respecting a few they were more timid. In the all-important art of prescribing there is much to be learnt from them, if we read their precepts and, above all, their case-records, with due judgment. In the preceding article I have thought it worth while to reproduce the chief points in a Report on Arsenic, which is now nearly half a century old. I now venture to offer to my readers some fragmentary notes on the uses of another of our great remedies, in part selected from the writings of our forefathers, with which I shall intersperse my own comments.

### *The Opinions of Sir Astley Cooper.*

The following very practical observations on Mercury are from the pen of Sir Astley Cooper, and were published soon after his death as Selections from his Note Books:—

“*Effects of Mercury.*—Brassy or smoky taste in the mouth—the gums white and swollen—the teeth unusually sensible to cold air and water—gums ulcerated about the roots of the teeth—the cheeks ulcerated opposite the dentes sapientiæ—the teeth loose and often painful—increased quantity of saliva secreted—bleedings from the gums and cheeks—sloughs from the gums and cheeks, and exfoliations of the lower jaw.

“Chilliness—sensation of cold water running down the back—pulse quickened—increased secretion of urine—loss of appetite—restlessness—sweating—purging—tenesmus, vomiting, irritation in the skin—pains in the joints.

“If an effect is produced by mercury, and from any cause

the use of the mercury is suspended, it becomes extremely difficult again to occasion a mercurial effect.

*“Increasing its Effect.”*—The warm-bath is the most certain mode of making the mercury affect the mouth. Mr. S—— had used mercury so as to affect his mouth for a node on the tibia; great inflammation came on in the bone, and it was necessary to suspend the use of mercury. When he had recourse to it again, the mouth could not be affected, although half an ounce of mercury was used in the form of ointment. I ordered a warm-bath, and in two days the mouth became sore. Mr. R—— had great difficulty in affecting himself with mercury; he used the warm-bath, and in three days the mouth became very sore.

*“Decreasing its Effects.”*—The effects of mercury are decreased by bark, wine, and stimulating food of all kinds—by opium more especially—also frequently by purges—in the mouth by a gargle of argent. nitrat.”

It will be seen that in the preceding notes Sir Astley mentions some symptoms which in the present day we never see, such as hæmorrhages, sloughs of the cheek, and exfoliation of jaw. We now give small doses, and carefully stop—short of producing symptoms such as those. His observation as to the protective power of tonics, wine, &c., is one which I can well confirm, and upon which, indeed, I have often insisted. I never prescribe quinine with mercury unless under special conditions, believing that it simply implies the necessity for double doses of the latter in order to produce a given effect. His observation as to the influence of warm baths in favouring the development of ptyalism was new to me when I read it, but it is quite in keeping with what I have long known as to the efficiency, in this direction, of warm rooms and, above all, of confinement to bed. Of late I have often advised syphilitic patients under mercurial treatment to take a bath every other night, and I think with the result of assisting the cure. It is quite possible that in prescribing opium with mercury in order to prevent bowel irritation, as is now almost constantly done, we ought to remember that to some extent the opium is protective. The observation that patients become accustomed to mercury, and that after one

salivation it is not easy to produce a second, is important and probably well founded.

I will now turn to the experience of another master in our art.

*The Opinions of Sir Benjamin Brodie.*

From a lecture by Sir Benjamin Brodie on the effects of mercury I extract the following:—"Upon first taking mercury, the patient frequently appears to improve in health and spirits, but if the medicine be continued for too long a period the very opposite effects to these are produced." The contrary to this has often been my experience, but everything probably depends upon dose. Brodie thought five to ten grains of mercury, with chalk, twice or thrice a day, efficient only for a slight mercurial action, and two grains of calomel, twice a day, hardly enough. I should not give more than a quarter of such doses.

Brodie believed that mercury could produce symptoms resembling those of syphilis, and he particularly mentions ulcerations of the mouth and throat, rheumatism, inflammation of the iris and nodes. He adds, "In some cases of these mercurial nodes you will yet find that mercury cures them." I cannot but think that he was too credulous in believing that mercury caused nodes, and so also as regards iritis. I have never seen any facts supporting such a creed.

Brodie insists that the patient's health should be well sustained whilst taking mercury. He also remarks that cold is an antidote to mercury producing its proper effects, and that if the patient be not easily affected he ought to be kept to a warm room. He was a firm believer in sarsaparilla as a substitute for mercury, giving a drachm of the extract in a pint of the compound decoction daily. He gives the following interesting description of a class of symptoms which we now seldom or never see:—

"Mercury sometimes acts upon the nervous system like a mineral poison, and symptoms similar to those which it produces in these cases may arise from arsenic, tartarised antimony, and iodine; these consist of weakness, and debility, constriction of the chest; small, feeble, and irregular

pulse; frequent sighing, and incapability of making any bodily or mental exertion. Mr. Pearson used to call this disease the mercurial erythysmus: sometimes there is vomiting and sickness, with convulsive trembling of the limbs; this affection generally arises from the mercury being improperly persevered in, and if it is left off, the symptoms will be in some measure arrested; but time alone will cure the disease, and thus allow the mercury to be eliminated from the system. Sometimes the tongue is covered with a thick, black, crusted fur, as in typhus fever; and if the patient is low and depressed, he will require ammonia, wine, and other stimuli.

I will next adduce a case which affords an illustration of the methods of treatment in vogue in the earlier part of Brodie's career. It was not under his care.

*The Treatment of Syphilitic Iritis half a century ago—Use of Mercury, Bleeding, &c.*

A woman, aged 41, went through a severe attack of syphilis in January. She had eruption, sore throat, and slight iritis. She recovered after a short course of specifics. In the following August, whilst in a state of debility and cachexia, one of her eyes was attacked by severe iritis. Her surgeon ordered mercury, opium, and antimony, and four days later she had mercurial fetor. The eye was worse, in spite of the mercury, and turpentine was substituted in one-drachm doses. After temporary improvement, the eye, five days later, had relapsed, and the pain was intolerable. Although the woman appeared very weak, she was now bled to twenty ounces, and bore it well. Three days after this, however, the eye was still worse, and the turpentine being considered to have failed, it was laid aside, and mercury again given. Two grains of calomel, with a quarter grain of opium, were ordered three times a day. Under this, in two days, the gums were again touched. Definite improvement did not, however, result until ten days later. It is then recorded, "The mercury has acted most powerfully, producing ulceration and swelling of the cheeks; the inflammation has diminished, and the pain is gone."

The patient was now very weak. She had been bled from the arm three times. The iritis lingered for a month longer, and finally disappeared under small doses of bichloride. On November 16th the surgeon in charge of the patient writes, "She was discharged quite well, and, I believe, free from venereal taint." Comments are added as to the great value of bleeding in syphilitic iritis, and the unwisdom of trusting to mercury.

I have abstracted the above case from a detailed narrative published fifty years ago.\* Some questions of much practical interest occur in respect to it. In the first place, we may note that the iritis was a second attack, and occurred six months after the recovery from the first and from the other secondary symptoms. Next, it was a very severe attack. Turpentine failed to do any good, although given in larger doses than we now usually prescribe it. The iritis persisted in spite of mercury. This we not unfrequently see; indeed, in some cases, iritis will begin in one eye whilst the patient is salivated for the cure of the other. Yet in the end it appeared to be mercury which conquered the disease. Although the abstraction of blood always gave temporary relief to pain, &c., it is impossible to join the narrator in the belief that it did any definite good. Respecting a very large majority of cases of syphilitic iritis, it is, I think, true that they yield very quickly to mercury. In some cases iodide of potassium is sufficient, and in a few atropine drops may suffice. There are, however, a few cases like the above which resist everything, and these require the utmost judgment for their management. It is the same respecting a few cases of syphilitic disease of the skin and of the throat. The modern surgeon has in atropine drops, as contrasted with the extract of belladonna of our forefathers, a remedy of much increased power. Apart from its invaluable effect in keeping the pupil open, it probably exercises a beneficial influence over the inflammatory process. If we attempt to contrast the treatment which this patient received with what she would

\* I do not mention the source from which I take this narrative, because I am obliged to criticise the treatment. It is reported in great detail and with much ability in a medical periodical.

probably have had in the present day, we may note that it was in a general way too heroic. The doses of all the remedies were too large, and the bleedings too liberal. Had mercury been given in smaller doses, and ptyalism avoided, it is probable that it would have been found more efficient. Had it been combined with iodide of potassium, it might have helped. Possibly if, instead of bleeding, quinine had been given with the mercury, it might have been well. In venturing these strictures, however, it is impossible not to admire the directness and courage with which the surgeon pursued his aims.

The case further illustrates several points in the natural history of syphilis. The attack of iritis which proved so troublesome was the result of a recrudescence of the disease, for the patient had been cured by a short course of specifics of a complete and rather severe outbreak of secondaries six months before. It is precisely these relapses which not unfrequently prove rebellious under treatment. I have recorded above (see p. 111), with an expression of doubt, Brodie's opinion that mercury may sometimes cause iritis. Although I have seen nothing which could lead me to believe that such is the fact, I must acknowledge that I have seen many in which it did not prevent, and not a few in which, as in the above, it apparently failed, for a time, to exert any power.

*Mercury as a possible cause of Jaundice—Jaundice during treatment for Syphilis.*

It was the opinion of some of the older writers that the administration of mercury occasionally caused jaundice. The cases which were cited in illustration were, however, always instances of the use of mercury in syphilis, and there remained the fallacy as to whether the disease and not the drug was the cause of the liver disturbance.

I have myself seen but few cases of jaundice occurring in the course of syphilis, and have not been able to form any very definite opinion as to its relations to that disease. A few cases by various observers are, however, on record. One such, which ended fatally, I will quote.

A young woman, aged 26, had been treated during nine months by interrupted courses of mercury for "pseudo-syphilis." She had been at least twice smartly salivated, although no secondary symptoms had ever shown themselves. She became emaciated, weak and rheumatic. Whilst fully under the influence of mercury by inunction, jaundice set in, and in three days she suddenly became maniacal, upon which coma followed, and she died in two days. Excepting general bile-staining the autopsy revealed only negative conditions.\* It is not in the least conclusive that either the mercury or the syphilis had anything to do with the jaundice, though it is certainly true that the latter developed during ptyalism. The patient had been taking arsenic for a long time. The cerebral symptoms, although possibly due to the latter, were more probably the result of bile-poisoning.

*On the Doses which should be given when it is not intended to salivate.*

In looking back on the practice of the preceding generation of surgeons in respect to mercury, our attention is chiefly attracted to the largeness of the doses which they prescribed. We must remember that they had a distinctly different aim to that which we pursue. They designed to produce ptyalism, and to do it quickly and sharply. We in most instances desire to avoid this result, and to allow the mercury to act quietly upon the blood and tissues without any obvious manifestations of its presence. Thus we may easily fall into the error of giving too little.

The solution of the bichloride of mercury is a most efficient remedy and very convenient in use, but, unfortunately, some have got into the habit of ordering doses which are much too small. I have seen fifteen drops ordered for an adult. A lady, who brought me a syphilitic infant, said that she had taken medicine all through her pregnancy for the benefit of the expected child. I found that she had taken only half-drachm doses, and they had, of course, proved inadequate.

\* I have unfortunately mislaid the reference to this case, and cannot now ascertain it. The abstract is made from a detailed report in an old medical journal.

A patient wrote to me, "I have no reason to complain of the treatment as, notwithstanding the disease and the quantity of mercury I have taken since May last, I never enjoyed better health in my life than I have done this winter, although I have had a great deal of hard work and exposure to all weathers, day and night." I looked up my notes of his case, and found that this patient had taken two-drachm doses of the solution of perchloride three times a day for ten months.

It is very difficult to formulate any rules as to doses in what we may call the quiet treatment of syphilis, when the aim is to procure the disappearance of the phenomena, but not to disturb the health. That we may often keep the disease absolutely in check whilst we are yet giving the remedy inefficiently seems very probable. My impression is that we ought, under such circumstances, always to give as much as the patient will bear without inconvenience, and that we ought not to content ourselves with the disappearance of symptoms. My own favourite preparation is grey powder, and in doses usually of a single grain. I much prefer to increase the frequency of the dose rather than to augment its strength. Not unfrequently this dose is well borne every four, three, or even two hours, the patient being instructed to take it regularly night and day. Even when a pill has to be taken six or eight times a day, the inconvenience to the patient is far less than that of the inunction plan or the mercurial vapour bath. If the importance of regularity be explained patients easily acquire the habit. In making these suggestions I am by no means thinking of syphilis only, for in the treatment of many other forms of chronic disease long courses of small doses are invaluable, and do not in the slightest degree risk injury to the health.

*Syphilis in its early stages suppressed but not eradicated by long courses of Mercury.*

A very definite illustration of the fact that a course of mercury commenced in the earliest stage of syphilis may prevent its development only so long as it is continued has occurred to me recently. I have seen many. In the present instance a man of thirty-six came to me first, in the sixth week after con-

tagion, with a well-indurated chancre. I prescribed my usual pill, a grain of grey powder every four hours. He began this on May 3rd and continued it till November, and during the whole of that period he had no secondary manifestations. His sore, which had quickly disappeared, never recurred. In November he contracted a gonorrhœa, and for it consulted another surgeon, who advised him to leave off his mercury. This he did. Two months later he came out in a general and well characterised papular eruption. He consulted me again for this rash a month or six weeks later still. It was then, in spite of some specific treatment, very well marked, and it was attended also by patches on the lips and tongue. The tongue was in a condition of syphilitic psoriasis. Thus it is clear that the six months' mercurial course had been sufficient to hold the disease very completely in check, but yet had not cured it.

It is as yet an undetermined question as to how long an "abortive" \* course of mercury should be continued. I find myself, however, as years go on, inclined to insist on longer and longer periods.

The case which I have adduced is of value not only as illustrating suppression without actual cure, but as a proof of the possibility of suppression. We see that the chancre vanished and that not a single symptom of constitutional infection occurred so long as the mercury was continued. It is one of those in which the prevention of symptoms was so complete that doubts might have been felt as to the nature of the chancre. By some it is, I know, customary to doubt the diagnosis of syphilis if no secondary symptoms have occurred. Yet we find that the proof was soon afforded when the specific was laid aside. Had the latter been continued it is very probable that the patient would never have shown any symptoms. Yet he would undoubtedly have gone through syphilis. Let me repeat that in these respects the case is no exception to rule, but illustrates what is usual. Under an "abortive" course of small doses, carefully watched, it is the

\* The term "abortive," as here used, means not inefficient but suppressive,—designed to procure abortion of the syphilitic disease—to arrest its development *ab initio*.

almost invariable rule for syphilis to end with the chancre. If, however, the course be prematurely stopped it is equally the rule for some manifestations to occur. The severity of these will probably depend upon the length of previous treatment. My experience is that the rash is under such circumstances usually a very mild one, and that it is not often attended by throat symptoms.

## NOTES FROM CONGRESSES AND CONTINENTAL HOSPITALS.

Two years ago, on returning from the Birmingham meeting of the British Medical Association and Berlin International Congress, I offered to my readers some fragmentary notes respecting topics of interest which had been brought under my observation on those occasions. During the summer of 1891 I made no journeys, but during that which is just closing I have seen much. In July I was in Dublin to attend the Tercentenary of Trinity College, soon afterwards in Nottingham at the Medical Association meeting, and I have now just returned from a month's continental tour which has comprised several cities, but of which the principal object was the Second International Congress of Dermatology, held under the presidency of Professor Kaposi, in Vienna. If I now venture to record a few reminiscences of these occasions, it must be with the clear understanding that I make no attempt to do justice to them, or to those who took part in them. As throughout my ARCHIVES my selection of subjects for notice is guided solely by my individual interests, I shall now consistently restrict myself to topics which brought new knowledge or new suggestions to my own mind.

The occasion at Dublin was one of historical and social rather than of professional interest. There were, of course, no medical meetings, and there was much to distract the attention from such pursuits and to seductively occupy the time. I made, however, a few hospital visits, and was some hours in the museums of the Royal College of Surgeons and in that of Trinity College. In the latter I had the advantage of the guidance of the present Professor of Surgery in the University, Dr. Bennett, one to whom the Museum owes

very much. In the College of Surgeons Museum every possible facility was afforded me for the inspection of the specimens which interested me. I was also favoured with an opportunity for the quiet examination of a large collection of drawings, &c., collected at different times, and not usually accessible. Amongst these I found some of great interest and value. As is, however, not unfrequently the case with drawings, their value was in many cases impaired by the absence of history of the patient.\*

*Tracheotomy Treatment of Diphtheria in Dublin.*

With Dr. W. Thomson I had some conversation on the subject of tracheotomy and other measures in the treatment of croup and diphtheria. Dr. Thomson is one of the few advocates for operative measures amongst the present race of Dublin surgeons. From a senior and leading operator I received an expression of most unqualified disapprobation of them. My inquiries resulted in a strong impression on two points: first, that the opportunities for experience have as yet been comparatively limited, there not having occurred in Dublin that prevalence of diphtheria which has recently been encountered in London and many continental cities; and secondly, that tracheotomy in diphtheria, unless performed by men of special experience in respect to it, is a procedure almost invariably resulting in death. On this latter point the facts which have accrued in Dublin do not differ in the least from those of Paris, London, and other places (see ARCHIVES, Vol. IV. p. 15, *et seq.*)

*Encrusting Periostitis.*

On stair-landing of the University Museum there stands the skeleton of a lion, which affords a most beautiful specimen of encrusting periostitis. Almost all the long bones are affected. This skeleton may pair well with that of Landseer's dog in the University Museum of Edinburgh, which a late professor used to cite as an instance of mercurial influence, the animal being supposed to have licked its master's paints,

\* Of these I was with great liberality permitted to bring away about a dozen in order to have them copied in London for our College of Surgeons collection.

and these being supposed to have contained mercury. The skeleton of a lion which had never had access to a painter's studio, and yet shows exactly the same malady, may be held to give a final quietus to this far-fetched hypothesis, and if need were to disparage yet further the notion that mercury can cause periostitis. The real nature of this encrusting periostitis—which is, for the most part, a disease of the lower animals, and of those kept in domestication—remains an unsolved problem (see ARCHIVES, Vol. II. p. 197).

### *Exostoses in Birds.*

In the Museum of the College of Surgeons there are some specimens (for me new) of the formation of huge ivory exostoses [on the bones of turkeys. Twenty years ago I described from the Brighton Museum, where it was shown to me by Dr. Ormerod, the thigh bone of a turkey surrounded by growth of ivory hardness.\* The specimens in Dublin are, however, yet more curious, and there are several of them. In one the whole of the space on each side of the keel of the sternum, normally occupied by the pectoral muscles, from which the carver cuts his slices, is symmetrically taken up by ivory-like growths. These rise to a level with the keel. I was told that the bird, a very fine one, was actually “served at a nobleman's table,” and that its pathological condition caused great disappointment. Several other adjacent bones are affected in like manner, and must have greatly increased the weight of the bird. These, although related to encrusting periostitis, differ in some features widely from it. It would appear that the turkey is the bird chiefly, if not exclusively, liable to these formations, and further, that they are quite compatible with good health.†

### *The Annual Museum of the British Medical Association.*

I may confess that my chief attraction to the meetings of the British Medical Association is its annual Exhibition or

\* See woodcut illustration in the *British Medical Journal* under the head of “Museum Notes.”

† I have many other notes from the Dublin Museums, but will defer them for the present.

Museum. In it I always find drawings, preparations, or models which interest and instruct, whilst they do not bore me. To the Section Rooms and the Addresses I am drawn by a much weaker force. As a rule, though not invariably, I can read an address or paper with less weariness and more profit than I can listen to one. In the museum, however, there are objects which no printed description could have enabled me to realise fully, and which can be appreciated almost at a glance. It is to be wished that the annual displays collected by our Association had more of the Museum and less of the Exhibition in their character. This may, however, be only an individual opinion, and there may be many to whom the displays of drugs, foods, instruments, and health appliances are more valuable than clinical and pathological illustrations. As regards the latter, I have also to make the complaint that they are but too often left in a comparatively uninformative state by the omission of adequate descriptions and case-histories. If the numerous clinical observers now amongst us who make it a duty, whenever it seems desirable, to procure permanent illustrations of their cases by photography or drawing would keep this Annual Museum in mind through the year, and send what they collect with full descriptions appended, the value of these collections would be greatly increased. They would indeed soon become, in these rapidly-advancing times, unrivalled opportunities for the easy acquisition of the newest clinical knowledge.

The Annual Museum at Nottingham was a good one, and contained much that I was glad to see. A series of preparations and models illustrating diseases of the brain, sent from the Wakefield Asylum, was particularly worthy of attention, and so also was a series of drawings, relating to various subjects, contributed by the surgeons of the Leeds Infirmary. Any one wishing to realise exactly what is meant by the term "*Erythema indurée des Scrofuleux*" (Bazin) had an excellent opportunity offered by some beautiful drawings shown (with many others) by Dr. Colcott Fox. So also of *Adenoma Sebaceum*, of which Dr. Radcliffe Crocker had some beautiful models. If I may venture to offer a hint to those

who have the management of these collections in the future, it is, that more space, and better kind of space, should be reserved for this, the properly professional and scientific, part of the annual display. The best and most accessible room should be always kept back from the clamorous and cash-backed demands of druggists and instrument makers, and reserved for clinical pathology. Although the early demands for space may be small at first, the whole of it is sure to be taken up in the end. Exhibitors of objects of this class are seldom business-like in the direction of sending their exhibits beforehand, and often prefer to be their own caretakers of their treasures in transit. Tradesmen, on the contrary, apply well beforehand, and but too often secure all the best space. I speak as one who on more than one occasion has had charge of the details of these temporary exhibitions when I advise that space should always be reserved for late comers, who very often bring the best things.

*The Congress Museum (Vienna).*

In connection with the Vienna Dermatological Congress there was an exhibition on the same plan as that which since the year 1868 has constituted an important feature in our British Medical Association meetings. It was arranged in a large room close to that in which the Congress met, both being part of the magnificent buildings in which the Imperial University has its home. Nothing could possibly exceed the convenience of the arrangements. Before and after the sittings the Museum was always full of visitors, and ample opportunity was afforded to all, not only to inspect its contents, but to examine them critically, and in company with others whose knowledge made conference valuable. Never was a better opportunity afforded for the informal interchange of opinion amongst those engaged in the same pursuits. My only regret was that this collection, large as it was, was not still larger, and that it did not display all the wealth of dermatological drawings, &c., which Vienna could produce. I was afterwards favoured to a private and necessarily hurried inspection of Professor Neumann's port-

folios, and felt regret that I and others had not been able in the Museum to go through them at more leisure. It is a pity that any pictorial illustration of interest should be hidden away in a private cabinet, for we none of us know the degree of interest which those which we thus seclude may have for others.

As an illustration of the great value of these exhibitions, I may mention that I had myself taken to Vienna a paper, illustrated by drawings, dealing with the subject (to me new) of superficial melanotic staining of the cheeks, accompanied by the formation of unpigmented epithelial cancer in close proximity. Of this I have now had five or six cases, and the pathological fact is one of great interest and suggestiveness. In the Congress Museum, on a screen appropriated to contributions from Professor Billroth's collection, I found a portrait which illustrated precisely the combination in which I was interested. It showed a face upon which was a large, quite superficial and non-ulcerated, black stain, and near to this stain, on the left lower eyelid, there was an ulcer in all respects resembling rodent cancer. This latter showed no pigment. There were other conditions of much interest in the portrait, which possibly brought the case into near parallelism with that which Mr. Willett permitted me to give in my last number from his wards in St. Bartholomew's. I must not, however, venture to say more on this point, as I have not yet got the history (which I am promised) of the Vienna case. In a collection of photographs sent to the Museum from Paris, I found yet another portrait illustrating this superficial melanotic staining, but in it there was no co-existing epithelial cancer. It is not by any means improbable that other observers may possess other portraits carefully preserved in their private portfolios which bear upon the same subject, and by the aid of which it might be much elucidated. I mention this particular subject only as an example of the advantages which might ensue if those who possess drawings would be kind enough to bring them all into public display at some of our temporary exhibitions. The Congress Museum had also its negative side. I noted that no single portrait was exhibited either from Vienna, Paris,

or elsewhere, illustrating the very peculiar and striking form of lymph angeioma, which I have called lupus lymphaticus. Nor does any Continental atlas contain a portrait.\* Those given by Mr. Malcolm Morris in the International Atlas were all from English sources. I have myself seen at least eight examples of this malady, and it is now more than twelve years since it has been described and figured. May we assume from this absence of illustrations that it is really much more common in England than elsewhere? The absence of portraits bearing upon adenoma sebaceum,† pityriasis rosea, and dermatitis herpetiformis was also to be noted. I mention these not in the least as pointing out deficiencies, but rather as suggesting that their absence may have some negative value as evidence. The collection was enriched not only by contributions from dermatologists, but by a large series from Professor Billroth, another from Professor Albert, and a most valuable series of specimens from the Pathological Institute. These latter Dr. Paltauf was good enough to demonstrate to us. From the Hôpital St. Louis, at Paris, a large collection of models and drawings had been sent. Some of these, in excellence of execution, were unsurpassed by any that I have ever seen. I will briefly notice a few of the exhibits which interested me most, but shall not attempt to classify them apart from notes of cases seen in the hospitals, and other matters.

*Influence of Exanthems in predisposing to Cancrum Oris.*

Amongst those sent from the Surgical Clinic (Billroth) was one showing cancrum oris. The patient, as usual, was a child, and the disease was noted as occurring after variola. The frequency, or indeed the almost invariable precedence, of an attack of some exanthem-fever has been strongly impressed on my own mind. Almost all the cases which I have had to

\* I am aware that one or two Continental cases have been published. In one common lupus co-existed; a fact of some interest for me.

† This disease was well illustrated by a series of beautiful drawings and models which Dr. Radcliffe Crocker had brought with him for a paper, but unfortunately they did not find their way into the Museum, and were exhibited only for a few minutes.

treat had followed measles. Here is another item of evidence casually offered bearing in the same direction. Not only does the specific virus of syphilis dispose to gangrenous affections, but all other similar forms of virus have in greater or less degree the same tendency.

*Cancer of the Skin secondary to Cancer of the Stomach.*

Amongst the pathological preparations in the Congress Museum was a series illustrating the form of secondary cancer of the skin which may occur in patients suffering from scirrhus ventriculi. The opportunity for seeing these specimens gave me the more pleasure because I have had, not very long ago, a precisely similar case. The facts of my own case are briefly as follows.\* A man aged about fifty came to me with a large area of infiltrated and indurated skin on one side of his neck. It was of considerable thickness, and as hard as it could possibly be. In the middle of the patch was an island of healthy skin, quite soft and supple. There was not much papillary growth, and no tendency whatever to ulceration. I felt confident that it was a secondary and not a primary form of scirrhus cancer of the skin. On inquiry, the man told me that he had been long under treatment for what was diagnosed as ulcer of the stomach, and that he had nearly died from vomiting and hæmatemesis. He had been kept alive for several weeks by nutrient enemata. He had finally recovered so as to take and digest food, and had even regained his strength sufficiently to make another voyage as engineer on a packet to the Mediterranean. On returning from this voyage the growth in the skin of his neck made its appearance. His recovery had been so nearly complete that the original diagnosis of organic disease of the stomach had been abandoned. When I saw the condition of his neck I was inclined to fall back on that suspicion, although his stomach symptoms were for the time in abeyance. The sequel was very conclusive. A few months after I had first seen him his sickness recurred; he obtained admission into the London Hospital again, and there died. *The post-mortem showed extensive scirrhus of the stomach.*

\* I will at some future time publish this case in detail.

The specimens which have induced me to narrate this case were contributed by Professor Kundart from the Institute of Pathological Anatomy. They consisted of a stomach which showed extensive carcinomatous infiltration, with ulceration extending from the pylorus backwards along the greater curvature, and of portions of skin from different parts showing various stages of scirrhus infiltration and growth. The first was simply a brownish discoloration with hardness. Next, in the centre of this, little indurations like minute cauliflower buds made their appearance. These buds grew, and formed by their confluence and growth masses more or less pedunculated, which showed no tendency to ulcerate. The largest of these growths (from the border of axilla) was as big as the palm of a large hand, and at its middle an inch high. It was made up of coarse papillary growths, and looked much like some forms of papillary mole, but a certain puckering at its edge showed that there was infiltration and contraction of the true skin, and revealed its true nature. There was no ulceration. I have been somewhat detailed in describing the features assumed by cancer of the skin when secondary to cancer of the stomach, because the conditions were very unusual, and because the occurrence is very rare. The peculiarities of all forms of secondary carcinoma are no doubt given in part by the organ from which the infective material is derived, and in part by that in which it is implanted. They thus present considerable variety, and their careful study becomes for purposes of clinical diagnosis of much importance.\*

*Tuberculous affections of Skin and Mucous Membranes.*

The relations of various affections of the skin and mucous membranes to tuberculosis and to "Scrofula," and the special appearances which they may present for recognition, constitute one of the most important, and not the least difficult, of the topics of the day. I will put aside for the present the whole of the lupus group, and will speak only of certain cog-

\* For the narrative of a very remarkable case, in which rapidly spreading cancer of the skin was secondary to some abdominal growth, see ARCHIVES, Vol. II. p. 121.

nate maladies which do not usually obtain that designation. On the screen devoted to drawings contributed from Professor Billroth's collection was one designated "*Tuberculose der Mamma.*" It represented the two breasts of an adult woman, both of them covered by inflamed and swollen skin, which presented extensive ulceration in separate patches, with flabby granulations and dusky discoloration. Some of the ulcers at a little distance from the principal ones showed small sloughs in their centres. It was an affection of the skin over the *mammæ*, rather than of the glands themselves, and I was reminded on the one hand of scrofulous ulceration, possibly secondary to abscess, and on the other of those ulcerations of the legs in young persons which have recently claimed the interest of several observers independently, and which were first described by Bazin\* under the name of "*Erythema indurée des scrofuleux.*" Its symmetry proved its constitutional origin, and was exactly parallel with what we see in the case of the multiple ulcers on the legs to which I refer.

From Professor Lang's Clinic we had a model of a tuberculous ulcer of the glans penis. It showed an unhealthy, much inflamed ulcer which surrounded the meatus. It was large enough to receive the end of the little finger. The history and the microscopic examination would alone furnish the diagnosis. Any one not informed on these points would have taken the ulcer for an inflamed chancre almost in a state of phagedæna. It had its differences, but they were too minute for me to attempt to describe them. I have myself in two cases, both in men above middle age, seen ulcerations about the meatus which I diagnosed as scrofulous, or as closely allied to lupus. In neither was there the least suspicion of syphilis, and in both cure was obtained with difficulty by repeated cauterisation. Both occurred some years prior to the discovery of the tubercle bacillus. I must therefore leave the diagnosis as to tuberculosis in some doubt.

Dr. Lang was kind enough to give me privately the history of his patient. The diagnosis was made quite certain by the microscope. The man was the subject of tuberculous disease

\* I am indebted to Dr. Colcott Fox for the reference to Bazin's description of this disease.

of the bladder and kidneys, and the ulcer in the meatus bore therefore the same pathological relation to the internal disease that tubercular ulcers of the larynx and tongue often do to pulmonary phthisis. It was the result of local infection. Dr. Lang told me that he had seen several other cases of tubercular ulcers on the glans penis, but none of them primary.

*Supposed Tuberculosis-infection from prick of finger.*

A specimen-model of what was called tuberculosis by inoculation was shown by Professor Albert, "Impf-tuberculose; verletzung und Infectionen mittels nadels-stiches." The forefinger, which had been pricked, was much inflamed, swollen, and dusky. In the finger-cleft was a secondary swelling, and another (a small abscess) on the back of the hand. A string of little infection-swellings (tending to abscess) extended up the forearm.

If my reader will refer to ARCHIVES Vol. IV., page 53, he will find a very similar case recorded, and I have the drawing of another from the hand of a butcher who cut his hand with a knife and subsequently had infection-abscesses not only in the injured extremity, but on the head and face. No one can doubt that in these cases the injury is the exciting cause of what follows. The site of the prick or cut is the part which first inflames, and from it the tendency to the formation of chronic abscesses and conditions allied to scrofulous lupus spreads. Clearly it is an infection-process. So far as that goes, I will not in the least dispute the correctness of Professor Albert's designation. But there may perhaps be still some room for debate as to whether such cases are instances of the implantation of bacilli at the time of the injury. In Albert's case it was a prick by a needle, in one of mine also it was a needle-prick. In neither of these is it very probable that the needle was laden with tuberculous matter. In my other case it is true that there was more risk, for the butcher might possibly have been cutting up tuberculous meat. I am, however, myself more inclined to suspect that the tubercular proclivities existed beforehand in the patient, and that the injury excited irritation only, and thus prepared the

tissues for their development. In other words, it may have been that bacilli or their representatives were already present, and waited only for inflammation-damage to permit their multiplication. The cases belong, of course, to the group of necrogenic lupus, with the clinical difference that they represent a more acute form of inflammation. Many cases of necrogenic lupus which in the sequel become very chronic and quiet, are, however, in their first stage attended by suppurative inflammation of a more acute type. I may also ask attention, as distinctive from the more usual sequences of tuberculosis, to the presence, in the cases under consideration, of excess of inflammatory swelling and the tendency to rapid formation of abscesses.

*Description of the Skeleton of a Short-Limbed Dwarf.*

In the Pathological Museum of the Heidelberg University I found a skeleton of unique interest. It was that of a short-limbed dwarf, or rather perhaps it should be described as an arrest of development of all the four limbs. It was remarkably like that of the "Norwich dwarf" (which I have described in the Pathological Transactions), but with differences which were of importance, as possibly affording some clue to the real nature of the influences at work in the production of these extraordinary skeletons. Briefly it may be said that in this Heidelberg specimen there was not the slightest trace of rickets, whilst there was abundant proof of deformities which appear to be out of relation with any constitutional malady of that class. Not a bone showed the slightest trace of bending. The ribs were slender but well-formed, and the pelvis, although small for the size of the trunk, was not in the slightest degree distorted. The skeleton was that of an adult, and so short that the top of the skull readily passed under my arm. The bones of the skull and trunk appeared to be of natural size and of perfectly normal development, the dwarfing was in the limbs only. All the long bones were very much shorter than normal. I had no opportunity for making exact measurements, further than that I ascertained that the radius was not more than  $3\frac{1}{2}$  inches long. All the long bones showed remarkable expansion of their articular ends, and overgrowth

in connection with the epiphyses. The ridges, &c., for the attachment of muscles were in many cases much exaggerated, but not in all. The shafts of the humeri and of the femora were in their middle thirds slender, perfectly straight, round, and smooth. So far from the ridges in these parts being in excess, they were less marked than usual. The bones of the forearm and of the leg were, however, whilst very short, somewhat thickened, and displayed coarse markings. Thus, for example, the tubercle for the biceps was at least three times its natural size. The carpus and digits showed very remarkable changes. Some of the carpal bones in the second row were ankylosed, with, if I remember rightly, union of two of the metacarpals. The metacarpals and the phalanges were all extremely short and thick. It appeared as if the digits could not have been more than an inch and a half long, and as if the hand had been more or less clubbed. Both feet were in the position of equinus, with slight tendency to varus. The os calcis was rather small, but the other carpal bones were as large, if not larger, than those of a normal foot. The metatarsals and all the phalanges were, as in the hand, very short and thick. The scapulæ were, as in the Norwich specimen, rather small and thin; but the coracoids presented a very remarkable condition which was not present in the former. Upon the ends of these processes was placed a bar of bone almost as long and as thick as the two last joints of a little finger. This bar sloped obliquely upwards and backwards, and downwards and forwards, resting by its middle on the coracoid, of which it formed part. The conditions, so far as I could observe them, were almost, if not absolutely, symmetrical. I have ventured to write the above description of them from notes which were taken very hastily, as I was much pressed for time.

Arrest of growth of the digits is, I believe, exceptional in dwarfs, who usually have full-sized hands and feet. So also are conditions approaching to clubbing of these parts. In the Norwich skeleton the hands and feet are well formed.

I confess that I do not see how the hypothesis of rickets, whether intra-uterine or post-partum, can be invoked to explain all the changes which I have described. An arrest of

development, in connection with some cause of which as yet we know nothing, appears to me to be the only suggestion.

*Stomatitis in association with a fatal form of Skin Disease  
(Pemphigus Vegetans of Neumann).*

In 1887 I read before the Medico-Chirurgical Society a clinical paper which described certain cases in which a peculiar form of sore mouth had been the precursor of a peculiar eruption on the skin and nails, and which, after a not very long course, tended to a fatal termination. Two of my cases had, however, after resisting all other treatment, been cured, and apparently saved from death, by the continuous use of opium. The eruption had in all cases been secondary to the sore mouth. In two cases it had closely resembled pemphigus, but with a remarkable tendency to the formation of papillary growths on some of the abraded parts. In some of the cases, however, these latter features had been quite absent, and the eruption on the skin had been but slight in amount and had differed but little from eczema. I gave the disease no name, but simply drew attention to its clinical features and to the extreme importance of the opium treatment. I was not at the time aware that any similar cases had been described, but not long afterwards Dr. Radcliffe-Crocker drew attention to the fact that Neumann, of Vienna, under the name of "*Pemphigus Vegetans*" had recorded examples of a disease in some of its features very similar.

Dr. Radcliffe-Crocker himself subsequently, in an able paper, brought before the Society the particulars of another case (fatal) illustrating the same combination of symptoms.

From the time that my paper was written until the present date, I have seen no additional cases which I should like to claim as belonging to the same category, nor, as far as I am aware have any been recorded by British observers. It was therefore with great interest that, during a visit to the wards of the Vienna Hospital, I saw another example of this peculiar form of sore mouth. The patient, who was a man of about thirty, had large patches on his lips and inside his cheeks, which were covered by a glutinous greenish pellicle. These

patches were abruptly margined, and the adjacent mucous membrane was congested. There was no history of specific disease, nor had any cause for the inflammation of the mouth been detected. It was not a severe case, the man being as yet in tolerably good health and wholly free from skin disease. The sores, however, were exactly like those which I had seen in my own cases, and they had as yet resisted all attempts at cure.

Professor Kaposi, under whose care the man was, gave his prognosis in the clearest terms. "Although," said he, "there is no skin disease as yet, an eruption will certainly follow. The disease will run its usual course and the man will die."

In connection with this peculiar malady it is desirable to remember that there are certain forms of common pemphigus which are attended by the formation of blisters and excoriations in the mouth. They are usually very severe cases and tend rapidly to death. In them, however, the character of the stomatitis is different, and the dermatitis is unattended by tendency to vegetation. It seems by no means improbable, however, that there may be some alliance as to cause between pemphigus and the cases under consideration. At the same time it may be open to doubt whether the name "pemphigus" is a convenient one for a malady which always begins with a sore mouth, and is by no means always attended by an eruption having any approach to a bullous character.

*The Hospital for Diseases of Children at Nuremberg.*

There is at Nuremberg a well-managed and not inconsiderable Hospital for Children. It was founded by Dr. Knopf, and is now under the joint superintendence of him and his son. I visited it with Dr. Erbstein, and was taken round the wards by Dr. Hasselberger, the resident physician. The latter had only recently vacated a similar post in Munich, in the hospital which has so long had the services of my friend Dr. Ranke. I was told (by Dr. H.) that at the Munich Hospital intubation has entirely superseded tracheotomy for all acute forms of laryngitis. Only in chronic cases, stenosis, papilomata, &c., is tracheotomy resorted to. Dr. Hasselberger told me that thirty-seven per cent. of

cases of diphtheria treated by intubation had recovered. At Nuremberg intubation is as yet only on its trial, and tracheotomy is still in favour. I was shown two children in whom the latter operation had been performed. In one of these one day had elapsed, and in the other three days. The latter patient appeared to be convalescent. In the former the child was still restless, with great distress from difficulty of breathing, and obviously in much danger.

*The cases of Contagious Vulvitis in Young Children.*

I was told that in several German towns there had recently occurred little epidemics of vulvitis in young female children which presented all the characteristics of gonorrhœa. Great interest had attached to the microscopic examinations. By one it was reported that a coccus exceedingly like the gonococcus had been discovered, and in another series of cases it was held that the microbe was not in any way to be distinguished from that of true gonorrhœa. The children who suffered were aged only from two to five years, too young for any probability of infection by vicious practices. It was believed that the real explanation was that the children had occupied the same beds with their fathers whilst the latter were the subjects of chronic discharges, and had been infected by the bed-clothes. It is also obvious that under such circumstances the mother might also very probably in turn become a source of danger, and that towels, cloths, &c., might yet be more frequent vehicles of contagion than the bed-clothing. I do not know whether the superstition prevails in Germany that if a gonorrhœa can be given to one who has never had it, the giver will lose it. This wretched creed in England sometimes leads to vilely selfish conduct, and to acts which, though not sexual, are yet criminal.

In the investigation of this class of cases (which occur occasionally everywhere) it is necessary to proceed with the utmost caution. The microscope has now given us the means (at least, so we hope) of distinguishing the cases of false gonorrhœa in children from those in which inoculation has really taken place. Even when gonococci are present, however, it is necessary to remember that they are by no means conclusive as to any

sexual act, and that several other possibilities remain for our investigation. Bitter injustice has not seldom been inflicted by the assumption that all contagious of this sort are due to criminal acts.

*Lupus Vulgaris following Strumous Periostitis.*

A very interesting example of lupus vulgaris was shown to me in the Nuremberg Hospital for Children (Dr. Knopf). The patient, a boy of ten, had his left hand with all its fingers covered with scars and still persisting lupus-infiltration. His ring-finger was shortened in consequence of necrosis of the metacarpal bone (soundly healed). On this forearm (left) was a very large patch of superficial lupus, and lastly there was one in the middle of the right cheek (flush-patch). He had also dense opacities in the left cornea from strumous ulcers. He said that he had suffered as long as he could remember, and it appeared likely that the whole had begun from the strumous periostitis of his metacarpal bone. At any rate the case illustrates the coincidence of two conditions typically strumous (ulcers of the cornea and necrotic periostitis) with lupus. It is to be added that great benefit had been obtained to all the patches of lupus from the injection of tuberculoid in very large doses. All crusts had been removed, and although it could not be said that the lupus was really cured in any one of its three sites, yet it was reduced to quiescence in them all.

There was another case of common lupus in this hospital, and a very severe one. Thus, judging from what I saw for myself in this hospital, I should not have supposed this disease to be so infrequent in Nuremberg as authorities tell us that it is.

*On the use of Arsenic without Medical advice.*

Dr. Lewin, of Berlin, the well-known pharmacologist, mentioned to me some interesting facts in reference to the internal use of arsenic for cosmetic purposes. He introduced the subject by a reference to the opinion which I published at the time of the Maybrick trial, that it was not usual for patients

to whom arsenic had been prescribed medicinally to become fond of it. I then said, and I am still of the same opinion, that there is in England no belief on the part of the public that arsenic is useful either for cosmetic or aphrodisiac purposes. With the exception of cases of psoriasis and allied eruptions in which its remarkable and unique efficacy has been discovered by the patient, we never in English practice meet with those who take it on their own responsibility. Usually the prescriber has to use persuasion to induce perseverance with a drug which is dreaded as a poison. Dr. Lewin assured me that the case was different in Berlin, and that there, not unfrequently, patients to whom it had originally been prescribed as a medicine, would develop a taste for it and refuse to leave it off. Young women, under the idea that it improved their complexions, would take it for years together. If such a creed obtained in England it is quite possible that similar results might ensue. Our maidens, however, as yet, have no such imagined knowledge, and there is amongst us no abuse of the drug by the public. As a matter of fact, I much doubt whether arsenic does, as a rule, improve the complexion in women, or act as a sexual tonic in men. If pushed in full doses, I believe that it often has the reverse influence in both directions, making the complexion muddy, the eye dull, and much reducing the virile appetite. A case which came under observation in Vienna, and which I shall mention hereafter, confirms Dr. Lewin's impression that there are cases of long continued use of arsenic without medical authority. In this case a girl, the subject of acne, had taken arsenic for many years regularly, and had induced keratosis of her palms and soles.

#### *Infrequency of Lupus in Bavaria.*

At Nuremberg, lupus is reputed to be not common in any of its forms. The same is said to be true of Munich and the whole of Bavaria. Nor is scrofula, or any form of tuberculosis of the skin, common. In connection with this it is interesting to note that pulmonary consumption is at least as frequent as elsewhere. I was assured by Dr. Epstein that these facts could be proved by the citation of statistics. In

Prague and through Bohemia, on the contrary, lupus is very common, and pulmonary consumption, although frequent, is not in excess.

*Favus contagious in a Family.*

I was told in Nuremberg of a family affected with favus. Five brothers and sisters suffered, and one of the subjects was an infant only ten months old. I asked at once, "Were they Jews?" "You are right, they were," was the reply. Here we have undoubtedly an instance in proof of the possibility of the contagion of favus when the opportunities of contact are frequent, close, and long continued. Favus is, as in England, a rare disease in central Germany, and there, as with us, its almost exclusive victims are the poorest of the Jews.

*Infrequency of Ringworm in Nuremberg.*

Ringworm of the scalp in children Dr. Erbstein assured me was quite rare, much more rare than tinea of the beard in adults. This statement was confirmed to me by several observers. Tinea versicolor of the chest in adults is reported to be common everywhere. Alopecia areata is said to be fairly common in Nuremberg. I was told the same in Vienna and Budapest. At all these places I was told that it was more common than ringworm. In attempting to estimate its comparative frequency, however, I may say that I did not myself see a single case of it in any hospital, whilst I saw several of favus, a disease reported to be much more uncommon.

The statements just made are based upon reports made in conversation. Dr. Beekh (of Nuremberg) was kind enough to give me his statistical reports of in-patient hospital practice for the last ten years. From them I collated the following table, which appears to show alopecia areata as an exceedingly rare disease. It will be seen, however, that it quite confirms the verbal statements made as to the rarity of other diseases of the tinea family (cryptogamic) and also of lupus.

A TABLE SHOWING THE FREQUENCY OF CERTAIN FORMS OF SKIN DISEASE AT THE NUREMBERG HOSPITAL.

Year.	Total of Skin Diseases, <i>a</i>	Psoriasis.	Zoster.	Urticaria.	Prurigo.	Sycosis.	Lupus.	Tinea Family, <i>b</i>	Alopecia.	Pemphigus.
1882	225	13	4	4	1	1	0	0	0	1
1883	174	7	2	4	2	1	0	0	0	1
1884	238	9	2	3	1	1	0	0	0	3
1885	178	11	1	1	2	1	1 <i>c</i>	0	0	0
1886	182	4	4	0	1	5	1 <i>c</i>	0	0	0
1887	287	10	3	3	0	2	0	0	0	0
1888	238	11	2	6	0	2	1 <i>d</i>	1 <i>e</i>	0	0
1889	216	10	2	7	0	1	1	2 <i>f</i>	0	0
1890	269	19	2	5	1	0	3	2	0	1
1891	289	20	5	7	3	0	4	2 <i>g</i>	0	0

*a* In the "Tinea family" I include favus, ringworm, and tinea versicolor.

*b* From the total, all cases of uncomplicated scabies are omitted. They usually numbered at least half of the patients treated.

*c* Probably the same case in the two years. It affected one hand.

*d* Of the face.

*e* A case of pityriasis versicolor.

*f* A case of favus and another of herpes tonsurans.

*g* Both cases of versicolor.

### *Prurigo (of Hebra).*

Great interest is always felt by dermatologists visiting the Vienna Hospital in seeing examples of the disease for which Hebra claimed exclusively the name of Prurigo, and which he described as beginning in childhood and lasting the life through. By general acknowledgment such cases are seldom, if ever, seen in England or the United States. They appear also to be gradually becoming more rare in Austria. I saw two "typical examples" in Kaposi's Clinic. One was in a lad of 14, and the other in a man of 30. In both, according to rule,

the legs were most severely affected, but in both the whole surface, excepting the head and hands, was more or less involved. The present doctrine is that it depends upon a congenital peculiarity of the skin, sometimes hereditary, and not wholly unallied to ichthyosis. In the young child it may in some instances assume the features of an urticaria. It is very rare amongst those who are cleanly and well cared for. This opinion as to predisposition is exactly what I have myself held for many years. There remains, however, still some difference of view as to the importance, or otherwise, of exciting causes. It is taught that these are nowise necessary, and that the pruriginous dermatitis begins spontaneously. I have long held that the irritation of fleas or lice, or the occurrence of imperfectly cured scabies, or even of a neglected eczema, may each in turn be the exciting cause of prurigo. I do not believe in spontaneity of origin, and by this incredulity I explain the infrequency of the disease in the richer class, and amongst those who attend carefully to cleanliness and clothing.

*Rarity of Pruriginous Affections in some Districts.*

The rarity, not only of Hebra's prurigo, but of all pruriginous affections, in some parts of Europe, is very remarkable. Dr. Fiertz, of Zurich, assured me that there was no prurigo of any kind there, and at Nuremberg it was spoken of as very rare, and the statistical table given at page 138 confirms the statement.

*Macular Ringworm of the Trunk, &c.*

Neither in the hospitals nor in the museums did I see a single example of what is known in Paris and London as pityriasis rosea. The Congress Museum, however, contained two large models of a malady which, if not allied to it, at any rate presents certain resemblances, and which, like it, is very liable to be mistaken for syphilis. I refer to "macular ringworm of the trunk." This is a disease which no one would think of calling ringworm at first glance, and which does not make any approach to the formation of rings. It occurs to adults, and covers the whole trunk with spots and small patches which

are of a brownish or copper tint, which desquamate in their centres, and which look exactly like syphilis. This description applies closely to the two models to which I am now referring. I have seen not a few such cases in practice, and sometimes under circumstances which made the diagnosis unusually puzzling, since the patients were willing to admit the possibility of syphilis. I have often searched for the ringworm fungus, and have always been disappointed. The disease gets well readily under treatment by a mercurial ointment or by sulphur baths.

One of these casts bore the diagnosis (by Kaposi) of "Herpes tonsurans maculosus." The other, from Neumann's Clinic, was named "Herpes tonsurans." In the latter there was some tendency to coalescence of the patches and to a diffuse pityriasis condition, but in the former the skin between the patches was quite healthy. All English and French observers with whom I exchanged opinions on the subject claimed this latter as one of pityriasis rosea. This term is possibly used by some of us too freely, and is applied to cases which are by no means all quite alike. Still there can be no room for doubt that it does connote an eruption quite distinct from ringworm.

#### *Recovery after Tetanus.*

In the Budapest Hospital I saw a boy who was convalescent from traumatic tetanus. On asking, however, how long the interval had been between the injury and the first appearance of symptoms, I was told "three weeks." This information abated my curiosity as to what the treatment had been. It is precisely these cases, with unusually long intervals, which do recover. See ARCHIVES, Vol. IV. p. 85. The triumphs of treatment come when the interval is less than a week.

#### *Shingles after Arsenic.*

The resident physician at the Communal Hospital at Budapest, and Dr. Epstein, of Nuremberg, both told me (independently) that they had had a series of cases of herpes zoster from the medicinal use of arsenic. Both observers appeared to consider the connection between the two as well established.

*Prevalence of Calculus in the Danube Plains.*

I was shown at the Hospital for Sick Children in Budapest a collection of four hundred urinary calculi. They had been collected during a period of rather more than forty years, and thus indicated an average of about ten stone-cases in children annually. I was told that the patients came chiefly, not from the city itself, but from the peasant population in the plain of the Danube. I suspect that the facts mentioned indicate a much greater prevalence of stone in these parts of Hungary than is found in Austria or Germany.

*Eczema Scrofulosorum (Kaposi).*

The term *Eczema scrofulosorum*, which was applied by Kaposi to a disease illustrated by two excellent models, was new to me. The models showed the disease on the thigh and on the abdomen of a young person. On the thigh, a patch the size of the palm of one's hand presented an aggressive and abrupt edge, and there was some appearance of thin cicatrix in the centre. It showed an eczematous crust, but was evidently in a very chronic condition. It reminded me, though by no means very closely, of some conditions which I have ventured to name *Eczema-lupus*. On the abdomen the conditions were different. Here lichen papules of a dusky red tint were arranged in lines and constellations (not in patches and not in the least like any form of lupus).

*Tuberculous Ulceration of the Skin of a Stump.*

Under the name of *Fungus Cutis*, Dr. Riehl exhibited a model of a stump of a thigh after amputation near to the knee. It was from a young woman still an inmate of the hospital. I had subsequently an opportunity for seeing the patient. The amputation had been performed on account of pulpy thickening of the synovial membrane of the knee. There was no proof of tuberculosis elsewhere. Thus the probability seemed very great that the skin had been infected directly from the diseased joint. The skin of the stump is now covered by unhealthy chronic ulcers, "scrofulous" or

“lupoid” under the older designations, but in which I was told that bacilli had been found. The rods of the parasite were to be discovered with much greater ease and in far greater abundance than is usually the case in lupus. We may therefore take these ulcerations as conclusively and typically those of tuberculosis of the skin. They were very large and numerous, and in many instances considerable areas of cicatrisation had been formed in their centres.

*Gummatous Enlargements in the Cauda Equina.*

From the Institute of Pathological Anatomy Professor Kundart also sent two beautiful preparations showing multiple gummata in the cauda equina. I was indebted to Dr. Paltauf for the demonstration of these very rare specimens. In both, many cords of the equina were simultaneously affected. In one the enlargements were fusiform; in the other they were larger and constituted roundish or irregular lumps. In seeing these preparations the thought occurred to me that possibly some of the cases published by Robert Smith of Dublin in his magnificent work on Multiple Neuromata may have been of syphilitic origin.

*Statistics as to Diphtheria and its Mortality at the Nuremberg Hospital for Children.*

The prevalence of diphtheria in Nuremberg appears to have been of quite recent occurrence. This is a fact of great interest, since it not only coincides with certain others in our English experience, but it may be held to prove that the disease depends upon contagion for its extension, and not upon local conditions.

In the year 1881 I find one case under the name of croup and 3 under that of diphtheria, with only one death. Scarlet fever in this year counted 20 cases and 4 deaths.

In 1882 diphtheria was the cause of 3 deaths, and scarlet fever of 3.

In 1883 there were 3 cases of diphtheria and 2 deaths. There were also 3 deaths from scarlet fever.

In 1884 two deaths occurred from diphtheria and one from croup. No deaths from scarlet fever.

The report of 1885 is not in my possession.

In the beginning of 1886 one child was remaining in hospital with diphtheria. Eighteen boys and 31 girls were admitted. Twelve boys and 11 girls died. At the end of the year some remained in. In this year there was no mortality from scarlet fever, and only 4 cases were admitted.

In 1887 36 boys and 43 girls were admitted, and 18 boys and 15 girls died. Two of each sex remained in the hospital when the year ended. In this year the mortality of scarlet fever was only 4, the number admitted only 27.

In 1888 45 boys and 24 girls were admitted, 14 boys and 15 girls died, and 4 remained in. In this year only one died of scarlet fever, and only 14 were admitted. In this year 4 cases, all boys, are counted under the name of "croup," without any mortality.

1889 is the last year of which I possess any report. Four cases were in the hospital when it began, and 4 when it closed. During the year 28 boys and 32 girls were admitted, and 15 boys and 16 girls died. Scarlet fever had no deaths, and only 6 cases were admitted.

Thus it would appear that the disease began to prevail in 1885-86, having before that supplied only sporadic cases. Since 1886 it has maintained a high average, and I believe that it still does so. It seems certain that there has been no kind of connection between the prevalence of diphtheria and that of scarlet fever, a fact to which also our English experience bears clear testimony. The statistics appear to me to possess some interest, as affording material for comparison with English towns. The tables before me do not give any information as to treatment.

*Recent Increase in prevalence of Diphtheria.*

That diphtheria has undergone a remarkable increase in some Continental cities as it has recently done in London seems to be the general impression. Nor does it appear to prevail in short epidemics only, but rather to persist for years in the districts where it has once become common. I quoted

in my last number (ARCHIVES, Vol. IV., p. 19) the facts from St. Thomas's Hospital, showing the very large increase of tracheotomy cases during the last few years. I have just adduced some facts as to its increase in Nuremberg, collated from the Annual Reports which were given me by Dr. Beckh. It is this increased, and apparently still increasing, prevalence of the malady which gives such great importance to the consideration of its treatment.

For the following facts as to the death-rate in different years, first in England generally, and secondly in London, I am indebted to our Registrar's statistical tables:—

*Death-rate from Diphtheria in England.*

In 1855 the annual mortality per million from diphtheria was	...	...	...	...	...	...	20
In 1858 it rose suddenly to	...	...	...	...	...	...	339
In 1859 it had risen to the highest ever attained	...	...	...	...	...	...	517
After 1859 it declined gradually with irregularities, and in 1872 was only	...	...	...	...	...	...	93
In 1889 it had by gradual increase attained that of	...	...	...	...	...	...	189
In 1890 it was	...	...	...	...	...	...	179

In *London*, diphtheria had a mortality of 284 per million in 1859. After that year it decreased. Since the year 1877, when it was only 88, it has been gradually increasing, with very slight variations, until in 1887 it was 235; in 1888, 319; in 1889, 390; and in 1890, 330.

To state the same facts in another form, there were in *London* in 1882 a total number of deaths from diphtheria of 857; in 1883, 952; in 1884, 951; in 1885, 904; in 1886, 851; in 1887, 953; in 1888, 1,311; in 1889, 1,588; in 1890, 1,417. I take these figures from Dr. Gayton's Report to the Metropolitan Asylums' Board.



## PLATE LIX.

### PHAGEDÆNA IN INHERITED SYPHILIS.

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I HAVE placed these three portraits side by side in order to illustrate the differences in destruction of the nose from lupus, and from the form of phagedænic ulceration which occurs in inherited syphilis. All these patients had suffered from the latter malady, and in all the nose had been destroyed. As distinguishing the appearances from those produced by the ravages of lupus, we may note, first, that the destruction is much greater, and that the cartilage and even the bones of the nose have been involved. It is to be observed also that the healing has been complete, and that the margins of the skin near to the scars are perfectly healthy. In lupus this is scarcely ever the case, the adjacent skin almost invariably remaining more or less thickened. The entire absence of any tendency to relapse is also a very marked feature in these cases, the direct opposite being, as is well known, the fact as regards lupus.

The disease which causes the deformities illustrated in these portraits usually occurs in children from six to fourteen years of age, and, I think, more often in girls than in boys. These three portraits are all copied from photographs in my possession, and are all those of girls. The correct diagnosis of the disease is of the utmost importance, for it begins as a rather acute form of phagedæna, and, unless arrested by adequate treatment, destroys the parts very rapidly. The treatment consists in the administration of iodide of potassium, and the application, free and repeated if necessary, of some powerful caustic to the parts.



Fig 1



Fig 2.



Fig 3

Inherited Syphilis.

West, New man, lith.



## SYPHILIS.

### No. XXXII.—*Indurations in Lymphatic Trunks in possible connection with Syphilis.*

Most observers are, I have no doubt, familiar with the occurrence of little hard knots which form in the subcutaneous cellular tissue, and are often seen in apparent connection with syphilis. They are seldom round, but often bean-shaped, and there can, I think, be but little doubt that their anatomical site is the lymphatic trunks. They are, however, never attended by cord-like thickenings of long tracts, nor are the glands ever enlarged. They never in my experience run the course of gummata as regards softening or breaking down. Their usual course is to persist for a time and then disappear. Although most frequently seen in those who have had syphilis, they are met with occasionally without any such history. They are quite different from neuromata in being neither painful nor tender. They differ from "rheumatic nodules" in that they are usually, although multiple, quite isolated, and show no preference for any special localities. They are not very usually met with on the hands or feet, nor near to subcutaneous bones. They may, however, be found on any part of the limbs or trunk. In some instances there may be a suspicion of gout.

An example of these peculiar indurations occurred in the person of a surgeon, Mr. H—— H——. He was thirty-three years of age, and had suffered from syphilis four years ago, for which he took mercury for a whole year. He appeared to have been quite cured, and at the time that he consulted me he had no indications of syphilis about him, unless these little indurations were to be counted as such. He was of very

dark complexion, and apparently in good health. He was losing his hair. His father was, he told me, very rheumatic, but he did not think that he had ever had a definite attack of gout. He had himself suffered at times from rheumatic stiffening of joints. The indurations about which this gentleman was anxious occurred on his hands, forearms, and feet. The largest was not so big as a pea, and most were about the size of shots. They were very superficial, and although apparently not beginning in the skin itself, they became at an early stage inseparably united to it. They were most of them of an elongated or oval form, with indefinite boundaries. He stated that they were not persistent, but that some would disappear and others come. They gave him not the least pain, and never showed any tendency to inflame. I advised him to rub in some mercurial ointment over the little "knots" three times a day. After two months' treatment by this, without any internal medicine, he called on me again. Several of the knots had melted away, but several still remained. One in particular near his left elbow, which had formerly been adherent to the skin, was now quite loose beneath it. He was quite clear in his opinion that some of them had previously disappeared independently of treatment.

No. XXXIII.—*On Phagedæna in Second contagions of Syphilis.*

I find in some surgical notes by Sir Astley Cooper an observation which supports what I have often remarked, namely that phagedæna often attacks the chancres of those who have suffered from syphilis before. "Mr. C—— had a chancre upon a penis previously diseased by chancre. This fresh chancre put on a sloughy appearance, and extended into the urethra, and it seemed to be the use of mercury which occasioned this state." The notes record that there was at first definite sloughing and afterwards phagedænic ulceration. Mercury on two occasions seemed to provoke a relapse of the sloughing, but so also did opium. It was a troublesome case, but finally got well under "sarsaparilla wine and black wash."

No. XXXIV.—*Chancre of the Nail followed by general Onychitis.*

Dr. M——, a surgeon, who consulted me with a chancre of the nail, in June, 1891, had during the secondary stage inflammation of all his nails, both fingers and toes. The nail of one of his great toes was for a time much inflamed. When I saw him in May, 1892, all the nails had grown again perfectly, excepting the one involved in the original chancre. This was in a condition of scar, much reduced in size, thin, and fluted.

I add this case to a number of others which I have previously recorded, which seem to show that secondary affections of the nails are very prone to follow chancres of the nail.

No. XXXV.—*Molluscum Contagiosum mistaken for Syphilis.*

Three years ago I saw an infant in consultation for symptoms suspicious of inherited syphilis. Its father strongly denied that he had ever had any venereal disease, and I believed him. A few days ago he came to me in much distress, saying that he had broken out in spots, and that he feared that after all, although he could not explain it, the suspicion which had been expressed must have been correct. I found, on stripping him, that he was covered with the little buttons of molluscum contagiosum. He was, as is usual when adults become the subjects of this malady, a frequenter of the Turkish bath. He said that his wife had also got a few spots.

No. XXXVI.—*Recrudescence of a Secondary Syphilitic Eruption—Papules developed in pairs.*

A very intelligent patient, suffering from a secondary syphilitic eruption, made a curious observation which I think worth recording. His eruption had shown a tendency to relapse (under inefficient treatment), and he noticed that the spots came, as he expressed it, in doubles. This he demonstrated to me. Everywhere there were two spots in close juxtaposition,

one being, by estimation, two weeks or so older than its companion. His eruption had occurred sparingly on all parts of the limbs and trunk, and the phenomenon in question was easily observed. Two explanations might perhaps be suggested. First, that a recrudescence of the syphilitic fever tended to produce a fresh symmetrical outbreak, and that the spots being unable to develop exactly on the parts already in possession, came out as near to them as might be; the other, and I think the more plausible, that the original spots infected the tissues close to them, and thus during a general recrudescence took an important share in locating the fresh eruption. So far as I know, the observation is novel.

No. XXXVII.—*On the use of Specifics internally in the treatment of Phagedæna.*

It was, I believe, a very general opinion of the older writers on syphilis that mercury was unsuitable in cases of phagedæna.\* There are, however, so many fallacies, that trustworthy observation becomes very difficult. This was, I think, well illustrated in a case which I reported not long ago (ARCHIVES). Phagedæna is in the main a local process, and is influenced chiefly by local treatment. It may occur to healthy persons, and wholly without reference to the previous use of mercury. Very often, as above stated, it happens to those who have had syphilis before. In all cases the surgeon is compelled to employ a complicated treatment, in part local and in part constitutional, and it is often almost impossible on this account to tell whether any one element in the treatment has been prejudicial or otherwise. My own belief is that it is usually wise to combine with the most vigorous local measures the use of specifics—mercury or iodides, or both. At any rate, of this I am sure, that I have seen many cases of severe phagedæna cured whilst the patient was taking

\* "For phagedenic primary ulcers I have always found mercury most injurious. They are most successfully treated by the application of strong nitric acid, immediately followed by a douche of cold water. The same application is also the most efficient for phagedenic ulceration of the throat, which if not checked will soon extend over the velum, uvula, and back of the pharynx." —From an address by Mr. Carmichael, 1834.

specifics freely. If, however, you trust to them and neglect local measures, it will be easy to come to the conclusion that they are very harmful.

No. XXXVIII.—*On the comparative efficacy of Mercury and Iodides in the treatment of Periostitis.*

A case in conclusive proof of the superior efficacy of iodide of potassium in competition with mercury for the relief of syphilitic periostitis came recently under my notice. It went even further than this, and proved that in some instances at least mercury is of no use whatever against syphilitic bone disease. A gentleman, who had come over from Australia for treatment, had suffered from periosteal enlargement of the lower end of one tibia for three years. During the whole of this long period he had kept the disease at bay by taking iodide of potassium. Doses of ten grains each, three times a day, always sufficed to reduce the swelling and take away pain. Invariably, however, if he left off the remedy for more than a week or two, aching returned and swelling increased. The enlargement of the bone was so considerable and so definitely local, and the persistence of the disease had been such, that I was led to advise trephining of the affected bone. Before doing so, however, as he had not recently taken any mercury, I determined to prescribe that remedy. The dose given was two drachms of the solution of the bichloride (gr.  $\frac{1}{8}$ ) three times a day. A fortnight later my patient returned to me with the statement that my prescription had not given him relief as his old one used to do. On the contrary, his node had swelled and become painful whilst taking it, and he had been obliged to leave it off and fall back on the iodide. The latter had immediately, as heretofore, taken away both pain and swelling.

No. XXXIX.—*Syphilitic Lupus closely resembling Lupus Vulgaris.*

An interesting example of a lupoid affection from syphilis after a very long period of immunity, occurred in the case of

Mr. H. S——. He was 39 years of age, and came to me for what he called eczema on his arm; it was, however, a well-characterized group of lupus spots. There was no ulceration; the only question was whether it was syphilitic lupus or vulgaris. The spots were arranged in irregular crescents, and had much the appearance of apple-jelly with very slight thickness. I found that he had a patchy tongue of a very suspicious appearance, and on inquiry found that he had been treated for syphilis twenty years ago in Paris. With the exception of his tongue, to which he had paid no attention, he had not had any reminders.

No. XL.—*Three Indurated Chancres (with eight years intervals) in the same patient.*

A barrister, Mr. R——, aged forty, was brought to me by his medical attendant in April, 1892, on account of a distinctly indurated chancre in the roll of the reflected prepuce. It was quite possible that it was the result of fresh contagion, but it was possible also that it was an instance of recurred chancre, for it was exactly in the site, as he believed, of a former one. It had been present for several weeks, but as yet no definite secondary symptoms had occurred. It must be remembered, however, that Dr. R—— had already given some mercury. It was a long crescentic ulcer, with very hard edges.

Mr. R—— told me that he had consulted me on a former occasion, and on turning up some notes made in October, 1883, I found that he had then told me that he had been treated eight years previously for what was said to be an indurated chancre by a well-skilled surgeon at Cambridge. He escaped secondary symptoms. When he came to me on October 9, 1883, he had a sore of five weeks' duration, on which different authorities had given different opinions. I felt no doubt that it was specifically indurated, and advised him to take mercury. This was done, and a month later all induration had vanished, and no secondary symptoms had followed.

Thus we have an instance of three occurrences of indurated

chancre in the same patient with two intervals of eight years each. On the first two occasions mercury was given, and no secondary symptoms occurred. The third is still under treatment. In each instance fresh contagion was suspected. It seems most probable that the first attack was true syphilis well cured, and that the two later were really fresh infections, the results of which were modified by the first attack.

No. XLI.—*Hemiplegia with early Syphilis.*

I saw, with Dr. L——, at Hampstead, in January, 1891, a case of hemiplegia in a very early stage of syphilis. The patient, a young Spanish gentleman, had been treated in the previous November for a chancre at the meatus and gonorrhœa; he had also a chancre in the frænum. One of the sores became phagedænic, and Dr. L—— had him admitted into a hospital and treated him by inunction. He had a sore throat, but no eruption ever showed itself. The inunction had been pushed to pyalism, and had then been wholly suspended. Thus it was only three months from the chancre, and only about three weeks after it had healed and the treatment been left off, that the hemiplegia occurred. The symptoms which attended the onset of the hemiplegia were somewhat peculiar. Mr. ——— attended a public meeting for which he had to act as reporter. This was on the evening of January 20th. On leaving the room he did not feel quite well, but he got home and went to bed. He had not previously suffered from headache, or had any cerebral symptoms. On waking in the morning he felt uncomfortable in his head, but, to use his own expression, "I managed to crawl downstairs to breakfast." He felt giddy, and could not walk well. On reaching the breakfast parlour he sat down in an armchair and went to sleep. After a short nap of perhaps ten minutes he awoke, and found that he could not use his left arm and leg, and could not stand. The right side of his face was also paralysed. He was taken upstairs to bed, and Dr. L—— was sent for. The hemiplegia was not by any means complete, but the limbs were very decidedly weak. Improvement soon began to take place, and when I saw him three days

later the lower extremity had almost entirely recovered, and the upper one was only slightly weak. He could frown with the whole forehead, but did not use the right side of his cheek well. He had no pain in his head, nor any defect of hearing or of sight; there had been no obvious weakness of his sphincters.

On the supposition that the hemiplegia was probably due to arterial disease, the mode of onset was certainly exceptional. It is not easy to see how the threatened, and partial, blocking of an artery should have caused the tendency to go to sleep; yet no doubt the theory of arterial obstruction is the most probable one.

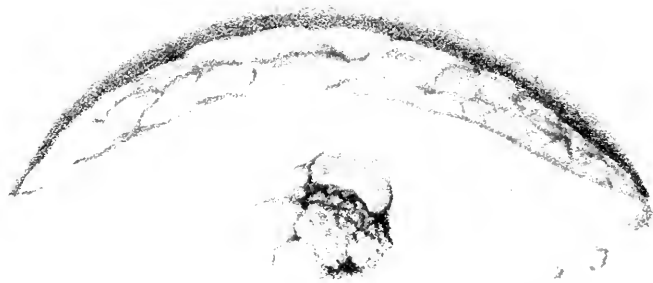


## PLATE LIV.

### CANCER OF UMBILICUS.

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IN this Plate are shown the conditions which were present in a case of cancer of the umbilicus. The patient was a lady of about 50 years of age, who had noticed a warty nodular growth on her navel for two or three months, and who was considerably out of health. As there did not appear to be any conclusive evidence of the existence of primary disease elsewhere, I thought it best to excise the affected part. This was done by cutting through into the peritoneal cavity, and taking away the elliptical portion shown in the left-hand figure. The peritoneal surface was found to be unaffected, but the scirrhous growth adhered to it. An incision from below into the indurated part displayed the section which is shown in the right-hand figure. The patient recovered well from the operation, but within two months of its performance there was evidence of nodular induration of the liver. Great irritability of the stomach supervened, and death from cancer of the liver followed about four months after the operation. Having regard to this sequel, I have little doubt that the primary disease was in, or near to, the liver itself, and that the growth on the umbilicus was a secondary one. The infection was probably carried directly by lymphatic trunks passing along the cord. I have had two other cases in which a malignant growth, making its appearance at the umbilicus, was really secondary to disease in the liver. In one of these a very remarkable tendency was subsequently displayed for the infection to travel along the lymphatic trunks. The disease spread downwards, on both sides, in the abdominal wall as indurated cords, and caused enlargement of the inguinal glands.





## DISEASES OF THE SKIN.

### No. LXX.—*A Papular Eruption following Measles in a Young Infant—Tendency to Gangrene—Long persistence.*

In March of 1883 I saw the infant child of a Mrs. S——, who lived in Vauxhall. The baby appeared to be in good health, but had been for three months the subject of an almost gangrenous eruption which occurred in scattered spots, looking remarkably like those of variola. This eruption was said to have followed immediately after measles, but as has just been stated, it had existed for three months. The infant had been taking medicine all the time;—whether it had taken bromides or iodides I could not ascertain. The eruption was said to have commenced on the hands. I possess two excellent drawings illustrating this case, one of them showing the chin and lips, and the other the backs of the thighs. The eruption was remarkable for the sameness of its character in all parts. It consisted of flattish papules arranged somewhat in groups, almost all of which had ulcerated, and presented greenish yellow crusts. The papules were at their bases vividly congested, but there was not the slightest tendency to diffuse dermatitis, the skin being in other respects pale and healthy. It could not be said that there was actual gangrene in any of the spots; that is, the skin had not sloughed in fragments of appreciable size. Clearly, however, a process closely allied to it had occurred. The eruption affected the chin, neck, and scalp, the arms, insides and backs of thighs, and the popliteal spaces. It appeared to prefer the flexures. There were a few scattered spots on the trunk. The prolabia

of both lips were affected, but, with the exception of the chin, the face had almost wholly escaped. On the lower extremities and neck many of the papules had no crusts. They were considerably raised and almost the size of split peas, looking much like those of small-pox or even suggesting a comparison with molluscum contagiosum. On the scalp the secretion was more free and the papules were less marked, the conditions somewhat resembling those of porrigo or impetigo contagiosa. The infant had a brother, aged four, living in the same house, who was free from eruption.

I must not by any means claim this as a case in which the eruption of measles became gangrenous. It seems, however, not improbable that the previous occurrence of measles gave peculiarity to the morbid processes, rendering them more prone to molecular gangrene. It appears to me probable that the case was one of a locally contagious inflammation allied to porrigo, which took its peculiarities from the immediately previous occurrence of measles.

I am not able to state anything as to the sequel of this case. The child, I believe, ultimately recovered. The case differs from most other forms of multiple gangrenous dermatitis in its chronicity. In gangrenous vaccinia and varicella the process is a rapid one, and either the child soon sinks under the irritation or the sloughs separate and the sores heal. In this instance the papules had persisted three months. In the last number of ARCHIVES I quoted from the St. Bartholomew's Hospital Reports the case of a child who had gangrenous dermatitis after typhoid, and stated reasons for the general belief that all the specific fever-poisons give tendency to gangrenous inflammations.

#### No. LXXI.—*Epidemic prevalence of Ulcerated Navel in Infants.*

At the Lyons Hospice de la Charité in 1857 ulceration of the umbilicus in new-born children prevailed as an epidemic. It caused the falling of the cord to be delayed, and produced sores which healed with difficulty. The sores were finally cured by chloride of zinc.

I mention this occurrence because it is of interest in connection with the epidemics of porrigo in infants which I recorded a few months ago. It is almost certain that the Lyons cases were due to some contagion conveyed inadvertently by the nurse in attending to the navel. It is important to observe that all the cases appear to have been alike, and they were not attended by other affections.

No. LXXII.—*On Sclerosis of Skin in the Coccygeal Cleft.*

Mr. K. S——, aged 65. He has had it more or less some years. The whole cleft is now hard and horn-like. It has itched somewhat. He has hard, rough, ill-defined patches in flexures of knees. In his occupation as engineer he is obliged to kneel occasionally. On his knuckles the skin is a little rough and thickened. He is in good health.

Once in hot weather he had a little eruption of red spots in his hands, which, however, soon went away.

This condition appears to be distinctly senile. I have never seen it in young persons.

No. LXXIII.—*Distension of Glands in the prolabium of Upper Lip.*

Every one is familiar with the appearance, in the buccal pouches, of long rows of yellow points produced by enlarged glands.

A surgeon, aged 30, consulted me with a similar state in the prolabium of his upper lip. It was not seen till the lip was everted, and was then very conspicuous. It extended with some imperfect breaks the whole length of the lip. The band was not wider than an eighth of an inch. The separate glands were easily distinguished though close together. He had been treating his lip for eczema, but as there was not the slightest irritation or discharge or peeling I advised him to let it quite alone. He was a smoker. There were no spots in his cheeks, but a few in the prolabium of his lower lip.

No. LXXIV.—*Long persisting liability to sores on the lips and in the mouth—Ringworm tongue—History of the same conditions in several members of the family.*

A gentleman named B—, aged 54, consulted me in January, 1889, and again in March of 1891, on each occasion on account of a sore mouth. His account was that he had been liable to ulcers in the mouth more or less all his life, and it appeared that he had often suffered from herpes on his lips. He told me that his mother, a sister, and a brother had all also suffered from sore mouths. His sister, who was ten years older than himself, had suffered many years in succession, and very severely, and had been accustomed to go to Royat for its cure. When Mr. B— came to me in 1889 he had numerous ulcers in his mouth and some herpetic sores on his tongue. His account of the persistence of the sores for considerable periods was inconsistent with the diagnosis of ordinary herpes. It was clear, however, that he was liable to sudden exacerbations. He was a smoker, and accustomed also to drink effervescents. He considered that all his family were more or less gouty. He was almost an abstainer as regards stimulants. I advised him to abstain from smoking and all sources of irritation to the mouth, and I believe that I did not see him again for two years. On the 7th of March, 1891, he consulted me, with a history that although he had been better he had never been well for long together, and he had now a very definite relapse. The condition now assumed was one of ringworm-like patches on the sides of the tongue. These presented bald areas with filmy white edges. The mucous membrane of his lips was much congested. Three weeks later he returned with a large ulcer on the mucous membrane of the upper lip. It had a florid edge, and was covered with a coherent pellicle which could be peeled off. It was exactly like the sores in the case of a gentleman from Dorset which I published some years ago.\* He had, however, never had any skin disease. I now prescribed for him Battley's solution of opium in three-drop

\* In "Medico-Chirurgical Society's Transactions."

doses, *nux vomica*, and *cascara*. Under this treatment, a week later he came with his lip very much less inflamed and the sore healing. Subsequently the lip got quite well, and the state of the tongue and the mouth generally was much better. He stated that under the opium he felt quite a different man. He had before felt heavy and low-spirited.

On August 24th, five months after the last note, Mr. B—— came to me again. He said that although he had quite left off smoking, and disused his artificial teeth, he could not get his mouth quite well. He had just returned from a six weeks' stay at Royat, where his tongue had been worse rather than better. He now told me that two of his children (of whom he had nine) suffered from tongues much like his own. Thus we had evidence of its occurrence in three generations. His own tongue was at this date as characteristically that of "ringworm" as any that I ever saw in a child. The patches changed their place frequently and were abruptly margined. In addition to this state of his tongue he was still liable to recurring sores, probably of an herpetic character, on his lips and cheeks. These never attained any great severity, and usually got well spontaneously in the course of a few days.

It seems probable that we have in this case an example of hereditary tendency to a recurring form of stomatitis; of this, one chief feature is the abruptly-margined patches known as "ringworm of the tongue." In the case of Mr. B—— himself, and probably also in that of his sister, this condition of the tongue appears to have been complicated with some herpetic tendency as regards the lips, &c. The ulcerations on the lips, however, showed a tendency to persist which is unusual in herpes. At one period Mr. B——'s mouth much resembled the conditions which I described some years ago, and which were curable by opium. Mr. B——'s sister, whom I never had the opportunity of seeing, was believed to have derived great benefit from the Royat waters, which contain arsenic. Mr. B—— himself did not improve at all under them, nor did the arsenic which I prescribed medicinally effect a complete cure. My impression is that he derived great benefit both from opium

and arsenic, but up to the date of my last seeing him they had not succeeded in effecting a complete cure.

No. LXXV.—*Catarrhal eruption on the limbs of erythematous character—Recurrence twice a year for seventeen years. (Peliosis Rheumatica?)*

Dr. Rolleston, of the Metropolitan Hospital, was good enough to send to me a man who had presented himself in his clinic, and who told him that I had formerly taken much interest in his case. The man was a coachman aged 45, in fairly good health, but nervous. His ailment was a recurring erythema of the limbs, the attacks of which were of short duration and disappeared spontaneously. It was for one of these which he had gone to the Metropolitan Hospital, and it had disappeared absolutely when he came for inspection to my house about a week later. I have not been able to find my notes of his case, nor have I any recollection of it, and the following statements are taken from what the man himself told me. He said that about seventeen years ago he was admitted into the London Hospital under Dr. Stephen Mackenzie's care for rheumatism, which he believed he had caught from sleeping in a damp bed. Whilst recovering from this he came out in a profuse eruption, and for this Dr. Mackenzie requested him to see me. He states that I gave a clinical lecture on his case in the theatre of the hospital. I have no doubt it was an example of what I used then to call purpura thrombotica, and which is frequently termed peliosis rheumatica. It affected the limbs only, and after lasting a short time entirely disappeared. Since that time attacks have occurred with tolerable regularity twice a year, in the spring and autumn. They have seldom lasted more than a week. The eruption is described as coming out very suddenly. The man states that sometimes in the course of twelve hours his limbs will be "smothered with an eruption of scarlet and blue patches." It is attended with some little feverishness and discomfort, and sometimes with rheumatic pains. The trunk is seldom or never affected, and the eruption disappears from the limbs in the course of a week.

It would seem probable that in this case the eruption should probably rank as of a catarrhal character. It recurs much at the same intervals as persons are liable to ordinary catarrhs, and it disappears as catarrhs do, almost spontaneously.

No. LXXVI.—*Very extensive and severe Scrofulous Disease in Childhood—Complete recovery (with deformities).*

I saw recently a case of much interest in reference to the occurrence of scrofulous abscesses in infancy. The child was vaccinated at three months, and all did well. Three months later an abscess formed in the left cheek, in the middle of the flush patch. Soon after other abscesses in various parts followed—under the chin, on the forearms, legs, fingers, and feet. She was for many months under surgical care (Mr. Pearce Gould and others) and her ailments excited much interest. From both thumbs fragments of bone from time to time came away. So extensive was the disease of the left arm about the elbow that it was thought that any recovery of a useful member was beyond hope.

The feature of chief interest in the case is the completeness of the recovery. The child is now a very healthy-looking, florid girl of ten. She is, perhaps, a little less than the average height of her age. Not a trace of active disease remains. All the ulcers have now for some years been soundly healed. She is, however, covered with scars. There is a deep one in her left cheek. Her left arm shows six or seven large ones, but they do not cripple the elbow in the least. She has perfect use of the extremity, with the exception that the thumb has been practically lost. Her thumbs are in the condition of being mere stumps, consisting only of the nail and pulp placed on the end of the metacarpal bone. The two phalanges have been lost by necrosis. She can oppose the stump of the right feebly, but that of the left is of no use. There are other scars about the hands and digits, but they do not involve disability. The fronts of her legs present large superficial scars.

The scars are those usual after strumous disease of cellular tissue, and wholly different from those of lupus. They are white, quite sound, and supple, abruptly margined, and in many places the fact that the ulcers were undermined is proved by the presence of almost pendulous nodules, or long rolls of elevated skin. (These need trimming.) No induration remains at the base of any of the scars with, perhaps, the exception of the one under the chin which is a little thickened.

It does not appear that there was ever any affection of the glandular system. The disease appears to have been restricted to the subcutaneous cellular tissue. It was not a disease of the skin. In the case of the thumbs it extended deeply to the periosteum and caused necrosis of bones, but nowhere else have joints been involved. The elbows, although surrounded by abscesses, were not involved, and their movements are still perfect.

The case illustrates the following points:—

Strumous abscesses may prove infective and become multiple.

Strumous disease of cellular tissue may keep for the most part to the tissue at first involved.

Strumous disease of cellular tissue may from proximity involve the skin extensively, and the bones in certain parts.

The recovery from very extensive, infective, strumous inflammation may in the end be very complete.

The lymphatic system is not prone to suffer in strumous suppuration of cellular tissue.

Acute and very severe struma in childhood does not always involve damage to the general health.

Strumous disease of cellular tissue is a malady wholly distinct from lupus.

To the practical surgeon such a case is of the utmost value as giving guidance in prognosis, and encouragement to persevering treatment. Especially does it teach a lesson as to the avoidance of amputation. I am informed that the question of amputation was often discussed, not only in reference to the thumbs, but as to the left upper extremity itself.

I had not much opportunity for going into the family history; the mother had been told that the disease was due to

vaccination, and, although she scarcely believed this herself, she was unwilling to admit anything as regards family tendencies. She was herself a florid, fairly robust-looking woman, and she had several other children.

No. LXXVII.—*Vaccinia Eruption resembling Variola.*

I have seen, during the last few months, two examples of a vaccinia eruption which looked exactly like variola. I have also been made acquainted with the particulars of two other cases, and am thus led to suspect that the event is not perhaps very uncommon. By a vaccinia eruption, I of course mean an exanthem—a symmetrical and constitutional eruption—occurring during the febrile period of vaccination. It usually comes out from the sixth to the ninth day simultaneously with the full development of the vaccination pocks. That some form of general skin eruption does not unfrequently occur at this stage has long been known to observant vaccinators, although ignored or even denied by others. Usually it is a slight affair, a mere erythema, or a crop of small transitory vesicles. The important peculiarity of the cases to which I now refer is that the eruption assumed the features of variola. The spots were in the first instance hard and shotty, and there next developed upon them large round umbilicated vesicles, which would have been regarded as most typical had they occurred as part of a small-pox eruption. They were sparingly scattered over the limbs and trunk. The two patients whom I have seen were both of them under the care of Dr. Colett Fox, to whose kindness I was indebted for the opportunity of examining them. In each of these the infant was very young, and had been vaccinated from arm to arm in a Maternity Institution. In both the arm was very much inflamed. There had been no known exposure to the contagion of small-pox, nor did any spreading from these infants takes place.

The appearance of variola-like pustules as a vaccinia eruption is of great importance as an item of evidence in support of the belief that vaccine lymph is a modification

of the small-pox poison. Pustules, such as were produced in the two cases to which I have referred, are never seen excepting either in variola or in vaccination itself. It is a most interesting fact that, although vaccinia appears to be thus competent to produce an eruption like variola, it does not generate a malady capable of spreading by infection.

### LXXVIII. — *Mercurial Erythema and Mercurial Eczema.*

We know but little in the present day of the disease to which our predecessors used to give the name of Erythema Mercuriale. So strong was their conviction that this disease was due to the drug, that it was thought worth while to record cases which were exceptional, and in which no mercury had been used. One such is given by the late Dr. Rutter, of Liverpool. He records that he saw the patient through an acute attack which lasted three weeks, and which affected the genitals, abdomen, limbs, head, and face. It was not a simple erythema, for there was much discharge of an offensive odour (seborrhœa). It had apparently begun as balanitis. The patient had on this occasion not taken any mercury. He, however, gave the history of a precisely similar attack seven years before, which had been apparently produced by salivation for a gonorrhœa.

The following is Sir Benjamin Brodie's account of what he called "mercurial eczema." I take the extract from the paper which I have already quoted from:—

"Some persons are subject to a peculiar cutaneous eruption while they are taking mercury; this is named the mercurial eczema; sometimes it shows itself only on the inside of the thighs, extending from the upper part near the scrotum, to about the middle of the limb. In some cases it extends over the whole body, and may go off in about five days; but sometimes at about that period, you find the skin covered with vesicles, which in time burst, and the cutis beneath them looks red and raw, and secretes an ichorous fluid; the cuticle and the fluid dry together, forming bran-like scales, which fall off, and give place to another set.

Sometimes this peculiar eruption will go on in this manner for some weeks."

One explanation of the greater frequency of eczematous eruptions during secondary syphilis in former days may possibly be that inunction was more frequently employed, and perhaps somewhat more roughly, than is at present the case. We still, however, every now and then see cases of severe and general eczema in connection with syphilis which cannot be so explained. I have in memory three or four such. They usually partake of the nature of erysipelas-eczema, and I am inclined to regard the condition as an accidental complication rather than as a part of the syphilitic malady.

LXXIX.—*A Case of Acute and Universal Erysipelas-Eczema in the course of Secondary Syphilis.*

A case illustrating the occurrence of acute universal dermatitis of the eczema type in the secondary stage of syphilis was seen by me about two years ago in consultation with Dr. Kibbler, of Hackney. The patient, a lad of two-and-twenty, had contracted an indurated sore, and had an eruption come out at about the end of the eighth week. He took some mercury and some iodide of potassium, and Dr. Kibbler thought it possible that it was under the influence of the latter that the eruption had changed its type. If it were so, however, it is certain that the eruption did not subside on leaving off the drug, but continued to develop into a far more acute disease. It finally assumed the type of an erysipelatoid eczema, and spread over the whole surface with œdematous swelling which entirely prevented the use of his hands and concealed the features of his face. During this illness (which had kept him in bed for a fortnight when I saw him) he had high temperatures and much general disturbance.

When I saw Mr. R—— (on March 7, 1891), although somewhat improved, he was still in the most deplorable condition. His head and face were so swollen that he could only just open his eyes, and his chin and cheeks were covered with greenish purulent crusts. On his hands there were many abortive vesicles and small pustules. The whole of his chest

and abdomen was covered with patches of a sort of lichenoid eczema of a dusky red tint, and so extensively confluent as to involve almost the whole surface. His upper and lower limbs were in a somewhat similar condition. His digits themselves were scarcely affected, the condition appearing to be one which was travelling from the trunk downwards. There was no mercurial fœtor, nor were his gums much swollen, but their edges were inflamed and secreting pus. At this date his chancre had for some time disappeared, and he had no ulcers in the throat. He had not taken either mercury or iodide for more than a fortnight. He had not, as far as he knew, ever been liable to skin disease before the attack of syphilis.

The question occurs in this, as in some other cases, as to whether the eruption ought to be counted as an erysipelatoid eczema due to one or other of the remedies which had been employed.



## PLATE LV.

### SUMMER ACNE.

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AMONGST the eruptions, which, although not wholly produced by summer are yet much aggravated by it, we have a form of pruriginous acne. This disease is well illustrated in one of the New Sydenham Society's portraits, and I have described it under the name of *prurigo æstivalis*. It is especially common in young persons, and particularly in young women. The eruption is almost always worse in hot weather, and gets almost or quite well in winter. The liability to this form of summer acne in most cases ceases between the 20th and 30th year.

The portrait which I now give well illustrates this malady as it occurred in a lady of middle age who had been liable to it almost from girlhood. She was in excellent health, but her face, neck, and the backs of her hands were, as is shown in the portrait, covered by little indolent papules, most of which showed the effects of scratching. The eruption occurred only on the exposed parts, and I was assured that, although it never got quite well, it disappeared almost wholly in winter, and was always at its worst in hot weather. The lady was married and had a family. The distinction of the disease from any of the ordinary forms of acne will be recognised, first, in the fact that the hands were affected, and next in the absence of any limitation of the papules on the face to the ordinary acne positions. I may also point out the absence of pustules and comedones.

I have referred to this disease in page 106 of ARCHIVES, Vol. ii.







## PLATE LXIV.

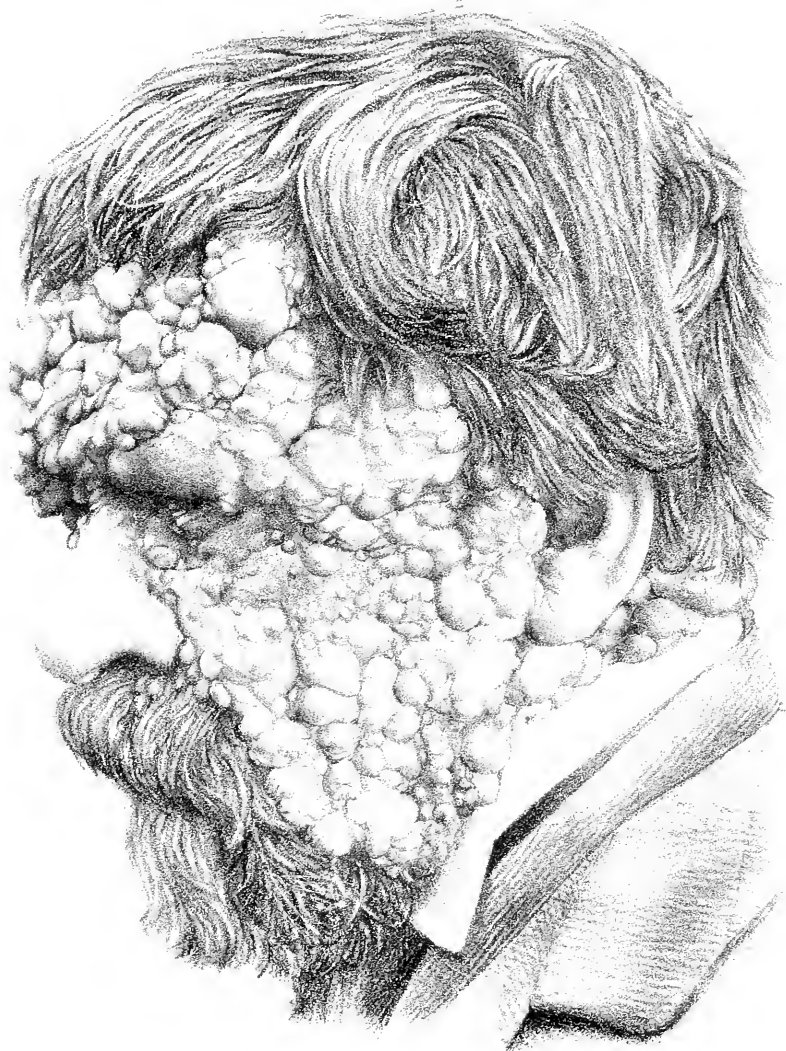
### MOLLUSCUM FIBROSUM.

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THIS portrait shows the present condition (1892) of a man who has for the last five and twenty years been under the observation of dermatologists in London. He now affords an example of most extensive molluscum changes. He is a man named Gray, and his portrait was published by myself in the New Sydenham Society's Atlas of Skin Diseases twenty years ago. It is Plate XVIII., and a full description of the man's condition is given in the catalogue.

A comparison of that portrait with the one which I now give is of great interest as showing the advance which the disease has made. At various times I have excised a great many of the growths from the face, more especially from the eyelids, where they were very inconvenient. It will be seen from the Plate that, although the molluscum growths are so numerous as to have become confluent over most of the exposed parts of the face, the ear and the nose are wholly exempt. The skin of the trunk and limbs is now affected in almost the same degree as the face, and it is of much interest to note that a certain number of tumours have formed inside the mouth on the palate, lips, &c. The tendency to the formation of these growths was first observed in early childhood, and they have been gradually increasing ever since. Although so severely disfigured the man still retains good health.

The case is a good example of what is usual in molluscum fibrosum, though it is perhaps one of the most advanced cases yet recorded.





## THERAPEUTICS, &c.

### No. XXV.—*Advantages of the Abortive treatment of Gonorrhœa.*

I ventured to write a few sentences in a former number of ARCHIVES in recommendation of the abortive treatment of gonorrhœa. My plan included the simultaneous use of purgatives, bromide of potassium, sandal-wood oil, and injections of chloride of zinc. These remedies, if all used together and no one forgotten, are, I believe, perfectly safe as an abortive plan in the most acute cases. The greater the severity of the case, the more desirable it is to employ vigorous measures. Begin with free purgation, and the rest is plain sailing. Since the paragraphs referred to were penned, I have come across an extract from a paper by M. Diday (1845) which has interested me. Diday held that copaiba acted more beneficially if combined with purgatives. He ordered an electuary of three drachms of the balsam, four and a half of cubebs, with forty-five grains of jalap. Of this one-half was to be taken in the morning and the rest in the evening, and five days is stated to be usually sufficient for a permanent cure.

It may be easily suspected that if the cure were not complete in the time, but few patients would be found willing to continue such a remedy. Since M. Diday's time we have got bromide of potassium, which is a very important adjuvant. We have also to a very large extent substituted oil of sandal-wood for copaiba. It is equally efficacious, far more agreeable to take, and much less prone to disagree. It does not produce eruptions.

In connection with the abortive treatment of gonorrhœa we have to consider the risk of complications. As to prevention of orchitis, cystitis, and stricture, I have no hesitation whatever in believing that the sooner the disease is cured the less is the risk of their occurrence. As regards the more constitutional affections, such as sclerotitis and iritis and gonorrhœal rheumatism, the question may possibly stand on different ground. I do not think, however, that it does so, and I believe that in order to prevent gonorrhœal rheumatism it is of first importance to cure the gonorrhœa. There is great reluctance on the part of some surgeons to try to stop a discharge after rheumatism has set in. Neither at this stage nor any other have I the slightest scruple. My theory of gonorrhœal eye-affections (I do not, of course, speak of true gonorrhœal ophthalmia due to direct inoculation) and of gonorrhœal rheumatism is that they occur almost exclusively in those who inherit gout, and that they are induced by the absorption of elements of contagion from the urethra. The sooner the latter is put into a healthy state the better ; it will then cease to supply the materies which, circulating in the blood, causes the iritis or the arthritis. It may at the same time be quite true that the cure of the urethritis may not have much influence on the rheumatism, for when once a joint has inflamed, it itself becomes, under the same law, a source of contagion to others. The seed has been already sown, and other plants have been produced, and you cannot arrest the process by eradicating merely the original one.

No. XXVI.—*The use of Cod Liver Oil in Rheumatism.*

Cod liver oil has obtained such a definite reputation against tuberculous and scrofulous affections that we are apt to forget its virtues in other maladies. In the first instance it was employed against chronic rheumatism, and gained enthusiastic opinions. I have before me the original report in reference to this latter use by Dr. Bardsley, of Manchester, who in April, 1807, wrote that it had then for thirty years enjoyed a very high local reputation. It had been much used

in the Manchester Infirmary by Dr. Percival and by Dr. Bardsley himself. The latter reports that it is variable in its efficacy, often in the mild and more common forms not doing any appreciable good. He thought it most useful in chronic cases in elderly persons and in women debilitated by parturition. He thought that it seldom did good unless it fattened. His dose was half an ounce to an ounce and a half twice a day, and he found warm beer to be, with the labouring classes, the favourite vehicle. If benefit were obtained it ought to be continued for six or eight months. He asserts: "I have seen a few patients recover entirely by the exhibition of the oil who on their admission into the house were unable either to preserve the body in an erect position, or support its weight on the lower extremities."

The consumption of cod liver oil in the Manchester Infirmary from 1776 to 1807 had averaged fifty or sixty gallons annually. It now amounts to four hundred gallons.

The profusion with which new chemical remedies have been supplied to us of late years may, it is very possible, have led to the comparative neglect of old ones, and that, perhaps, not always to the advantage of our patients.

#### No. XXVII.—*Taraxacum with Nux Vomica in Liver Disease.*

I have recently seen a young man, now aged twenty-nine, concerning whom his father told me that I had "cured him of a drunkard's liver nineteen years ago." He is now in very tolerable health, though still suffering somewhat from dyspepsia. He has continued to take the medicine which I prescribed for him so long ago ever since, not quite continuously, but whenever his liver is out of order. He avers that nothing else which he has tried has so good an effect upon his health. When he was brought to me at the age of ten he was very much out of health, and the diagnosis of cirrhosis, or "drunkard's liver," had been confidently given by a distinguished provincial physician. His case had excited considerable interest before I saw him, and his parents had been assured that he was not likely to recover. With this history I was much interested in obtaining a sight

of my prescription which was reputed to have worked such wonders, and fully expected to find that it contained mercury. Such, however, was not the case. It consisted of five drops of tincture of nux vomica and half a drachm of taraxacum juice—to be taken three times a day. These doses were originally ordered when the boy was ten years of age, and for a year or two afterwards he continued them uninterruptedly with the most definite improvement in health. I never saw him excepting on the occasion of the first prescription. As he grew older he had somewhat increased the dose.

Taraxacum has been styled “vegetable mercury,” and so far as its influence on the liver is concerned the two drugs appear to possess very similar powers. Its efficiency is, I believe, much increased by the combination of nux vomica. The chief point is, however, to give it in a sufficiently large dose. The doses in common use are much too small. A case of what may be called acute xanthlasma (see ARCHIVES, Vol. II.) in association with severe sick headaches, which I saw about two years ago, has apparently been greatly benefited by the use of taraxacum in full doses. We began in the first instance with small doses of mercury, but the vegetable drug was subsequently preferred. Under its long-continued use almost the whole of the xanthlasma patches have disappeared.

#### No. XXVIII.—*On the Influence of Season on Health.*

Although I am not able to appeal to any accurate collection of statistics, I yet feel but little doubt that the month of March is one in which those liable to gout and rheumatic gout are specially prone to suffer. My experience is most definite in reference to gouty affections of the eye. The same patients return to me, over and over again, in the early spring with attacks of recurrent iritis. I had a number of such cases during the last spring, and several of the patients told me that they were liable to annual attacks about that time of the year. In some the attack occurs with remarkable punctuality. In one of the most marked cases of recurring iritis which I ever saw, and in which I had the opportunity of observing the patient during a long series of

years, the attacks occurred repeatedly in the same week towards the end of February. It is not improbable that several conditions favour the development of such maladies in early spring. Chief probably amongst them is the occurrence of east wind and ungenial weather, which may act both directly upon the nervous system and indirectly upon the blood by diminishing the action of the skin. Then, too, we must remember that winter, as contrasted with summer, is to many people a time during which but little exercise is taken, whilst the consumption of food, and especially of animal food and stimulants, is increased rather than diminished. The cumulative results of this will probably be reaped in the spring months.

Amongst the conditions which are distinctly under the influence of weather and season, and liable to recur in the spring months, we must count irritability of the skin. The skin is liable to be dry, and probably the functions not only of the sudoriferous but of the sebaceous glands are much interfered with. Thus many patients complain during east winds and spring weather of a general pruriginous condition, which may be attended with more or less of lichenoid eruption. In this we have the *prurigo hiemalis* of Duhring, but there is also a *prurigo æstivalis* due to exposure to sun, and which in some instances may become a formidable malady. It is not, however, only in reference to diseases of the eye and skin that the influence of season may be traced, and I cannot but think that results of some value, in reference to the etiology of many obscure disorders of function, might accrue from carefully collected observations as to the influence of season on health. The resources of civilization have no doubt done much to equalize the seasons. Our food varies far less with time of year than it used to do; we are better clothed, and, above all, exempt from malaria. In all these directions our forefathers suffered much. Their estimation of the various risks is plaintively expressed by Jeremy Taylor in a passage which I shall trust to be excused for quoting:—

“Nature hath given us one harvest every year, but death hath two: and the spring and the autumn send throngs of men and women to charnel-houses. All the summer long

men are recovering from their evils of the spring, till the dog-days come, and then the Syrian star makes the summer deadly. The fruits of autumn are laid up for all the year's provision, and the man that gathers them eats and surfeits, and dies and needs them not, and himself is laid up for eternity ; and he that escapes till the winter only stays for another opportunity, which the distempers of that quarter minister to him with great variety. Thus death reigns in all the portions of our time. The autumn with its fruits provides disorders for us, and the winter's cold turns them into sharp diseases, and the spring brings flowers to strew our hearse, and the summer gives green turf and brambles to bind upon our graves. Calentures and surfeit, cold and agues, are the four quarters of the year, and all minister to death."

## MISCELLANEOUS.

### No. LXV.—*Dwarfing of the Radius after Detachment of the Epiphysis in Childhood.*

A very interesting example of dwarfing of the radius after injury to its carpal epiphysis came under my notice in the wrist of a medical friend. During a consultation I noticed that the ulna of his right wrist projected greatly, and, having asked permission to examine it, I found the ulna at least three-quarters of an inch longer than the radius. There was not so much obliquity as is usual in these cases. The wrist was simply placed at the distance named above the end of the ulna, the lower part of the forearm and hand being nearly straight. I was told that the condition had resulted from an accident which occurred at the age of four.

### No. LXVI.—*Senile Arteries of very large size with good health—Temporals not enlarged.*

In the case of Mr. J. B——, æt. 69, a short, very florid and stout man, who had enjoyed excellent health, I found very large arteries. His radials were easily felt at the back of thumb, and his radio-palmaris was in both hands as big as an ordinary radial. His tibials were also very large, but his temporals were not especially visible.

I asked him if any one had ever noticed any peculiarity in his pulse, and he said “Yes; eight years ago Mr. Lund, of Manchester, before whom I went for insurance, looked very grave, and said that my pulse was very slow. He afterwards told me not to think anything of what he had told me, and assured me that I was good for twenty years.”

I found no murmur at his heart, but it was probably large. His pulse was slow, and exceedingly strong and full.

The case is of interest because the condition had attracted attention so long as eight years ago, yet no inconvenience had accrued.

Some risks of spreading thrombosis and its attendant gangrene, and some of rupture of cerebral vessels, probably attend these cases of senile enlargement of arteries. They are, however, only remote. I cannot in a general way associate these large arteries with any special cause, nor make them the basis of any special prognosis. They occur solely in association with advancing age, and almost solely in the male sex.

#### No. LXVII.—*Fatal Gangrenous Stomatitis in Adults.*

In the recent number of the St. Bartholomew's Hospital Reports (1891), two cases are recorded of conditions in adults somewhat resembling cancrum oris in children. In both, ulcerative stomatitis resulted in dropping out of teeth and alveolar necrosis, and finally gangrene of the cheek. Both cases ended fatally, the one after more than four months, the other after about one month. Both had begun insidiously as sore lips or sore mouth, and in both the last stage of gangrenous extension was short. Both the patients were men, one of them forty-seven and the other thirty-one. Mr. E. W. G. Masterman, who records these cases from the practice of Mr. Marrant Baker and Mr. Marsh, states that no special cause for the disease could be discovered in either. One of the men was a tea-taster and the other a packing-case maker. Mr. Masterman informs us that tea-tasters of Indian tea are apt to get sore lips, and in some cases the condition advances to stomatitis with necrosis of alveolus, and ends in death. Both of the cases differed from cancrum oris as seen in children, in the fact that the alveolus was affected very early and the soft parts became gangrenous only in the last stage. The reverse of this is, as is well known, the rule in children.

#### No. LXVIII.—*Subcutaneous Indurations about the fingers.*

An old gentleman of seventy has a solid, flattened, oval,

firm, fleshy tumour over the knuckle of his left forefinger. It has been present six or eight years. I do not know that I ever examined any growth quite like it. It is adherent to the skin, and quite loose upon the deeper structures. It does not, however, in the least, infiltrate the skin, and there is not the slightest trace of redness or inflammatory action about it. It is a flattened cake-like mass, an inch and a half in length and an inch broad, and probably in the middle about a quarter of an inch in thickness. It covers the knuckle joint, and extends downwards over the metacarpal bone of the index finger. There is nothing of the nature of a bursa about it, nor does there appear any reason to connect it with gout.

My remark above that I have not seen other cases exactly like this, must be held to apply to its size and its non-infiltration of the skin. Indurations about the fingers, attached to the skin and infiltrating it, are of course not very uncommon, and especially, I think, in the subjects of gout. They seldom, however, attain the size of that described, and are firmly incorporated with the deep layers of the skin.

No. LXIX. — *The trunk of the Third Nerve injured by a shot—Description of the subjective symptoms at the time of accident.*

An instance of complete paralysis of the third nerve from a very singular and exceptional cause came under my notice in the case of a gentleman from Yorkshire, named T——. He had been struck, whilst out shooting, by a single pellet of ordinary partridge-shot, which had entered his upper eyelid on the right side, a little above the inner canthus. He was sent to me by Dr. Adams, of Dingwall, with the statement that the symptoms from the first had been those of complete paralysis of the third nerve. The lid had drooped, the pupil was widely dilated, and movements upwards, downwards, and inwards were lost. The wound had been probed but the shot could not be felt.

In the first instance there was much ecchymosis of the eyelids. Twelve weeks had elapsed between the date of the accident and Mr. T——'s visit to me, and during the latter

part of this period there had been gradual symptoms of improvement. The first gain had been the ability to lift the upper lid, and next a diminution in the size of the pupil. When I saw him the various muscles appeared to have regained their power in an almost equal degree. He still had divergent strabismus, and the pupil was still twice as large as the other. The pupil, however, acted freely on exposure to light, and he could with effort accommodate sufficiently to read ordinary print. He could use all the external muscles supplied by the injured nerve, but none of them quite perfectly.

I inquired as to the symptoms which had attended the accident. Mr. T——, an intelligent and observant man, said that he had no idea at the time that he had been shot. He felt as if some one had struck him on the forehead with a brick, and almost immediately afterwards he fell backwards. He then got up again and fell backwards again. After this he recovered, but felt very giddy and was sick. He was assisted home and put to bed, but during the next two days he continued to be very sick.

The symptoms described were possibly consequent on the shot-pellet having entered his brain, but they may perhaps have been due only to the sudden disturbance of vision, diplopia, &c. In the course of about a week he was quite himself again, with the exception of the third-nerve paralysis.

No. LXX.—*On the importance of keeping local Registers of Disease.*

Sir George Mackenzie (who travelled in Iceland with Dr. Holland) writes in his journal:—"We were gratified with the sight of Mr. Hjaltalin's parish register, in which is an entry, made annually, of the state of each family in the parish. Under the head of each family were entered, in separate columns, the condition of each individual; their age, whether confirmed or not, whether able to read, general conduct, abilities, &c.; also a list of the books belonging to each family." Mr. Hjaltalin was, of course, the village pastor.

The conditions of the village clergyman and the village doctor, as regards the demands upon their time, are of course

very different. It is, however, I cannot but think, much to be desired that, amongst those of us who are placed under favourable circumstances, more effort in the direction of an attempt at keeping local registers should be made. Mere death-lists, if accurately and fully kept, would become, in the course of years, of great value. I mean lists which should assign and classify the causes of deaths, aiming at a degree of accuracy and detail much greater than that attained by the registrar. Yet more useful, though, perhaps, involving much more labour, would be chronicles of the prevalence of non-fatal maladies—a journal of daily practice—with reference to season, weather, conditions of residence, family tendencies, and the like. There are plenty of young surgeons, well-trained observers, zealous for the development of knowledge, and not unambitious of scientific reputation, who might perhaps find in professional work of this kind efficient counter-attractions to lawn-tennis, &c. Unfortunately, it is too much the habit to think nothing worth investigation but what is rare, whereas it is really in common things that our knowledge is most defective. We need in medicine a reform much like that which Wordsworth effected in poetry. We need to come down from our stilts, and to be willing to take interest in subjects which, because they bring to us our daily duties, but too often appear common and insignificant.

I have met many clergymen who, in the quiet of rural parsonages, had kept notes of rainfall and wind; and others who knew for twenty years back the days when the first swallow had been seen, and the first cuckoo heard, but I have seldom found a medical man who had anything more accurate than his memory to trust to as to when he had seen cases of diphtheria, croup, or mumps. A village surgeon might do well to take Gilbert White \* as his model, but should keep for the most part to professional topics.

\* "He Boswellised the Birds; he took down the familiar conversation of Nature," was the comment on White of a medical friend in whose company I made a pilgrimage to Selborne. Perhaps I shall be told that White himself did not keep to his own profession. Well, for that he is to be more than pardoned, but the case is very different with us.

No. LXXI.—*Horace Walpole's experience in reference to cold-catching.*

“ Sometimes a walk in the grounds would intervene, on which occasions he would go out in his slippers through a thick dew ; and he never wore a hat. He said that on his first visit to Paris he was ashamed of his effeminacy, when he saw every meagre Frenchman whom even he could have thrown down with a breath, walking without a hat, which he could not do, without a certainty of that disease which the Germans say is endemial in England, and is termed by the natives *le catch-cold*. The first trial cost him a slight fever, but he got over it, and never caught cold afterwards ; draughts of air, damp rooms, windows open at the back, all situations were alike to him in this respect. He would even show some little offence at any solicitude expressed by his guests on such an occasion, as an idea arising from a seeming tenderness of his frame ; and would say, with a half-smile of good-humoured crossness, ‘ My back is the same with my face, and my neck is like my nose.’ His iced water he not only regarded as a preservative from such an accident, but he would sometimes observe that he thought his stomach and bowels would last longer than his bones ; such conscious vigour and strength in those parts did he feel from the use of that beverage.”

It is not improbable that there is some exaggeration and much inexactitude in the above statements. At any rate of this I am sure, that, if correct, Walpole's experience was very different from that of most people. Many can, it may be admitted, easily acquire immunity as regards going out hatless. Exposure of the hairy head to the open air is by no means one of the commonest causes of cold-catching, and the wearing of a hat may be held to be, for the most part, a matter of habit. I know many persons who care nothing about their hats, and will go without one even in a cold wind, but who yet dare not enter a damp, unused room or sit five minutes in a draught. I never heard of any one of catarrhal susceptibility who had by any training whatever acquired the ability to sit, without risk, in a draught. Nor

can many in the least help themselves in reference to damp feet. Above all, a damp room, one which has not been used for a week or two, is sure to give a catarrhal subject a cold. It is interesting that Erasmus noted this and thought English rooms (that is, rooms without stoves) especially dangerous. Water-drinking (even of iced water) is certainly no preventive of catarrh; indeed it may be suspected that abstainers suffer more than others. The catarrhal susceptibility is at its lowest when the blood is well charged with alcohol. There is an important anecdote told of the elder Darwin (of Leicester) which enforces this text.

If I were asked as to the best means of reducing catarrhal liabilities, I should say, clothe warmly, live in a dry locality and in a dry house, use cold bathing, and take food and stimulants as liberally as may seem judicious. I would add, on no account attempt to harden yourself by getting wet or sitting in draughts.

The real truth about Horace Walpole is probably that he never was, in any strong sense of the words, a catarrhal subject, but that he had been bred up in the notion that it is impossible to go into the open air without a hat. He easily acquired by practice the ability to do this, and as regards the other susceptibilities simply he never had them.

No. LXXII.—*A typical and severe case of Raynaud's phenomena—Maternal grief as a cause—Approach to the conditions of diffuse Morphœa.*

I saw, with Dr. Clarke of Clapton, a very remarkable example of Raynaud's disease in which some of the phenomena resembled diffuse morphœa. The patient was a lady of thirty-nine, who, although never strong, had in the earlier part of her life enjoyed fair health, and manifested no peculiarity of circulation. In childhood she had suffered from chilblains, but not severely. Her father, whom I saw at the time of my visit, was a remarkably vigorous man, who said that he did not know what it was to have cold hands or feet. The disease in our patient appeared to have commenced very definitely about four years ago, and to have been

due to severe emotional disturbance. Just before her hands began to die, Mrs. G—— had lost her only child. He was a promising boy of six, and died of diphtheria after only a few days' illness. Mrs. G—— took her loss very much to heart, and for some time afterwards spent long periods every day at the cemetery. About this time she began to suffer very much from cold hands, and her fingers would die. Her feet were affected in a similar manner, but much less severely. By degrees this susceptibility increased, being always worst in cold weather, but never wholly absent.

I saw Mrs G—— on August 20, 1892, during very hot weather. She was confined to her bed, and in a state of extreme suffering from gangrenous ulceration of the tips of several of her fingers. Her fingers were stiff, slightly swollen, pale and tallowy. Several of them were livid and slightly ulcerated at their tips, and others showed scars consequent on former ulceration. The skin on the backs of the hands could not be pinched, and the general conditions might be described as board-like. They differed, however, somewhat from those met with in well-characterised scleriosis, in that there was no demonstrable atrophy of the skin, the tightness and high-bound state being much less marked. The changes were also restricted to the hands, and almost to the digits. There was no appreciable change in the skin of the fore-arms. In the feet there was no evident hardening of the skin, but the toes were distinctly dusky at their tips. There was an inflamed sore over one malleolus, which had been caused by a slight bruise. The state of Mrs. G——'s face was very peculiar. The skin was not actually board-like, as in morphea, nor did it show any definite stigmata. It was, however, somewhat tight, and was covered with desquamating erythematous patches. She could close her eyelids and lips easily, but said that they felt more or less stiff. There was no change in the skin of the neck or chest. Mrs. G—— was thin, and had emaciated considerably of late. The erythematous condition of her face had been observed only during the last six months. Very distinct paroxysmal attacks were described, and they would occur often two or three times in the day. Mrs. G—— said that she knew when an attack was

coming on by a peculiar feeling of aching and discomfort in the limbs. Then her face would flush and her fingers become white. After the stage of pallor had lasted a short time, it was followed by one of duskiness, during which they became quite livid. Her nurse, who was an observant woman, told me that the smallest quantity of stimulants, or even a cup of hot beef-tea, would make the face flush up in the most extraordinary manner. Milk did not do it.

In contrasting this case with one of diffuse scleriosis we must chiefly take note of its history and of its paroxysmal character. It must be observed that although the local conditions present similarities, they are by no means quite identical. Thus, neither in the face nor in the fingers was the condition of atrophic thinning and stiffness, often so characteristic in scleriosis, at all approached. The limitation of the changes to the hands and feet must also be kept in mind.

#### No. LXXIII.—*Hæmoptysis in the Aged.*

Petit, the great French surgeon, at the age of seventy-seven (on April 17, 1750) was seized with spitting of blood. He died on the 20th. I have not been able to find any details as to his illness, excepting the appended quotation from the "Eloge" pronounced by M. Louis, which Mr. Bailey, the Librarian at the College of Surgeons, has been good enough to obtain for me :—

"Il eut dans l'espace de six mois deux ou trois oppressions de poitrine que quelques saignées avient calmées : il lui en resta une difficulté habituelle de respirer qui augmentait au moindre exercice un peu violent. Il fut attaqué d'un crachement de sang considérable, le 17 du mois dernier (Avril, 1750) et il mourut le 20, au commencement de sa soixante et dix-septième année."

This fact is not without its interest in reference to what Sir Andrew Clark has recently written as to hæmoptysis in the aged (see Transactions of Medical Society, 1891).

The occasional occurrence of profuse, or even fatal, epistaxis in the aged has of course been for long well known. In such cases the surgeon is occasionally consulted, and plugging of

the nostrils may sometimes be thought needful. So far as my observation has gone, these attacks do not usually occur in persons known to be the subjects of special arterial disease, although, of course, in the senile this can never be excluded. They appear to prove the possibility of local congestions of mucous membranes in persons apparently in good health, which relieve themselves by hæmorrhage, which latter may be profuse and almost uncontrollable. Sir Andrew Clark insists upon the absence of obvious arterial disease, especially of capillary fibrosis.

Amongst those who have confirmed Clark's observation is a Malta physician, Dr. Busutil, who has recorded three cases, one of them fatal, in the *Revista Medica*.

The treatment recommended by Clark is by saline purgatives and iodide of potassium. To these I will venture to add, as a means to the arrest of the hæmorrhage, the use of the continuous pediluvium, the temperature of which should be well kept up. I have never once plugged the nostrils for epistaxis since I knew of the efficiency of this simple measure.

In connection with these cases of severe hæmorrhage from mucous surfaces we may suitably consider certain others in which the blood is discharged from the surface of a morbid growth. In most instances of hæmorrhage from cancer we may reasonably suspect that some artery of greater or less size has been opened in the course of extending ulceration. I do not, however, think that this can be held to be the cause in all, for the attacks of bleeding are not single ones but are recurrent, and sometimes persistent for much longer periods than would probably be the case if an artery were opened. My impression is that cases of the latter group are usually of the nature of surface hæmorrhages, and very similar to those which occur from the nose or lungs. In support of this view it may be noted that often the malignant disease in hæmorrhagic cases is attended by growth rather than ulceration. The worst examples of recurrent bleeding from cancerous growths which I have had to do with have been in cases of cancerous disease of the lower bowel, attended by the production of polypoid masses. I attended many years ago an elderly clergyman who had come up to town in very tolerable health

on a visit to friends. He had in his rectum a large polypoid mass of cancerous growth which gave him but little trouble. Suddenly he began to suffer from bleeding, and this was so profuse and so frequently recurrent that in the course of ten days he was reduced to a most alarming condition. After a fortnight in bed under the use of ergot and other measures the bleeding ceased. He regained his health, and lived in tolerable comfort two years longer. A precisely similar case has been under my care quite recently, and has for the present been cured by similar means.\*

No. LXXIV.—*A very remarkable Example of Repeated Attacks of Hæmorrhage into the Tissues of one Thigh.*

A young gentleman who was brought to me from Belfast presented a most remarkable example of recurring liability to hæmorrhage into the intermuscular spaces of his lower limbs. He had had what he called repeated attacks of rupture of veins, in consequence of which his legs had been so much damaged that he was now obliged to walk with crutches, and in consequence of retraction of his heels could only bring his toes to the ground. Both lower extremities were very much shrunken, the atrophy involving almost all the muscles alike. There was no absolute paralysis of any one set of muscles. In the left leg common sensation appeared to be very much reduced, and the knee-jump was quite lost. Yet he was extremely sensitive to tickling of the sole, which, indeed, appeared almost to give him pain. He himself confidently attributed this numbness to the attacks of hæmorrhage into the limb from which he had suffered. It had followed on the last of a series of attacks of hæmorrhage, which had been a very severe one, and occurred about eight months ago. In that he said the limb had been enormously swollen, and he had been confined to bed for ten weeks on account of it. During most of this time, spirit and opiate lotions had been

\* The reader may find an interesting case of fatal non-tubercular hæmoptysis in the last volume of the Clinical Society's Transactions, by Dr. F. Hawkins, page 237.

applied. When he left his bed the joints of both knee and ankle were somewhat stiffened, and his heel drawn up. It was difficult to estimate the degree in which sensation was defective. He always perceived the prick of a pin, though not acutely, and he could generally tell when touched by the finger. He allowed, however, tolerably firm scratching with a pin's head without being able to recognize it. The numbness was greatest on the dorsum of the foot and over the toes, and shaded off gradually on passing up the extremity. Above the knee he could feel as well on one side as the other. In the right limb the patella was ankylosed to the femur, but there was some motion between the tibia and femur. The joint had not the slightest appearance of a scrofulous affection, there being scarcely any thickening of any part, and no scars of abscesses. The disease in it had occurred many years ago, and had lasted for long. So far as the history could be obtained, it seemed probable that it had been of a hæmorrhagic nature. I was told that incisions had been made into the swelling, but that no matter had ever been discharged. It occurred to me as possible that the anæsthesia of his left limb might be due to defect of circulation, and that his attack might have been one attended by plugging of the femoral artery. I could, however, easily find his posterior tibial on that side, and its beats were not more feeble than that of the other. Both his feet were cold, and the right was clammy. My first thought on seeing this young man's legs and lower extremities was that he was the subject of infantile paralysis. But the history was conclusive against such a diagnosis, and so also were the facts that the muscular weakness was general, no single set of muscles being affected, and that there was some degree of anæsthesia.

I must now attempt to give some history of the case as I obtained it from the patient himself and his father. It appeared that there was no known history of the hæmorrhagic diathesis in the family. He was one of a family of seven, four sisters and two brothers; and none of the others had suffered from hæmorrhages.

There was believed to be a strong tendency to gout on his mother's side. Most of his mother's relatives had gone out to

America, and not much was known as to the details of their health. This lad had been supposed to be a bleeder all his life. When quite a child, if he had a cut, or bit his tongue, very troublesome bleeding had always occurred. His father said that the tongue after being bitten had sometimes continued to ooze for three or four days, and that he had often had to consult a surgeon for the arrest of the hæmorrhage. He described the bleeding as a continued oozing, but said that it had never gone so far as to make them anxious about the child's life. During boyhood there had been very troublesome attacks of nose-bleeding, but these had ceased since the liability to hæmorrhages into the limbs had shown itself.

Mr. McA—— remained in London about a month, during which we endeavoured to improve the condition of his muscles by massage and electricity. The re-action of the muscles was imperfect. During our treatment a slight attack of general ecchymosis occurred, attributable probably to the rubbing. There was some slight swelling and a general appearance of bruising, but no signs of any large vessels having given way. He was able at this time to get about with his crutches, and enjoyed fairly good health. He never suffered from headache, and the only complaint which he made indicating inequality of circulation concerned a liability to flush on his face and head if he exerted himself, and to break out in perspiration on those parts. His pulse was usually sharp, but compressible, and he continued very pale. In general aspect, in liability to flush, and in the character of his pulse, this lad much resembled my patient whose case is recorded at p. 13, Vol. III., and who had suffered from hæmorrhages into the eye.

The following is an extract from a letter from Dr. Dunlop, of Holywood, who sent the patient to me:—

“The last attack of hæmorrhagic infiltration took place early in January of the present year (1891), and when I saw him the whole thigh was involved and swollen to an enormous extent, the pressure giving him great pain, and the loss of blood blanching him very much. The pain was so great that I had to give him morphia to a considerable extent. The lead and spirit lotion after a considerable time relieved him, and ultimately absorbed the blood. So little will cause injury and extravasation, that I was afraid to use either massage or much friction.”

Dr. Dunlop has been good enough to inform me recently (Sept., 1892) that our patient's condition has much improved during the past eighteen months. He has not had any return of hæmorrhage.

No. LXXV.—*Liability to temporary total blindness on assuming the erect position.*

A lady who had consulted me about arthritis, told me incidentally that she was "liable to lose her sight." On inquiring what she meant, she said that any sudden movement, but especially suddenly rising to the erect position, would place her for a short time in total darkness. She thought that the darkness lasted usually "as long perhaps as you could count thirty." On two occasions, when holding a candle, she should, she said, have set fire to objects near her had not her friends prevented it. She was accustomed to carve at table, and several times on rising to do so had been obliged to wait for a minute or so because in total darkness. Her sight always returned in a very short time, and without any headache or other inconveniences. She considered that her sight was good, but for a week past she had desisted from reading because it made her head ache. I found on trial that her vision was not so good as she imagined. She could, however, see  $\frac{3}{8}$ , and could read No. 4. On using the ophthalmoscope I found both discs involved in neuritis, their edges blurred, and the trunks of the vessels concealed. There were no white dots or streaks, and my son and I, who examined her together, agreed that there was no evidence of albuminuria. Subsequently, however, having obtained a specimen of the urine, we found that it was of very low specific gravity (1005), and loaded with albumen.

I record this portion of a most interesting case solely in reference to the symptom described. It is one not often met with, and I have never known a patient describe such definite and frequent attacks in connection with change of posture. The ophthalmoscope fully explained it. No doubt the temporary failure of sight was due to the inability of a weak heart to overcome the local impediments to arterial circulation caused by neuritis.

No. LXXVI.—*Senile Hypertrophy of Arteries—No evidence of Cardiac or Visceral Disease.*

I mentioned in the last number of ARCHIVES, p. 257, my belief that there are cases in which the arteries undergo hypertrophy independently of disease of heart or kidneys. The condition is, I think, usually one of senility, and not infrequently leads to inflammatory thrombosis and gangrene. My note-books contain a good many examples of this condition.

Mr. P——, aged 80, has during the last few years several times consulted me on account of eczema. He is in perfect health, and has been accustomed all his life to take a great deal of exercise. He has lived most temperately. His father died at 84, and his mother at 65. His heart-beat is quiet and regular, and he never suffers from palpitation. His arteries are remarkably large. Thus his pulse at the wrist can be very easily counted by the eye, and is easily felt between the metacarpal bones or in the superficialis volæ. His temporals are tortuous and large, but not increased in ratio with the radials. The femorals and popliteals are also large, but I could not detect either the anterior or posterior tibials. He has had some symptoms suggestive of impediment of the circulation in his legs, and it is very possible that some degree of occlusion exists. He has had several attacks of sudden pain in the legs. Twice this pain seized him while going upstairs. It was located just behind the knee, and was so severe that he would have fallen if he had not caught the banister. He remembers that six years ago he had a similar attack of pain in the right leg, and says that he has occasional shoots of pain which make him feel as if he would fall. Mr. P—— is a tall, rather thin man.

No. LXXVII.—*Tracheotomy and Intubation in the treatment of Diphtheria.*

It is exceedingly difficult to explain the differences in the ratio of success from tracheotomy in croup at different hospitals and in the hands of different surgeons. At the Highgate Infirmary, as noted in the last number of ARCHIVES, p. 21, Dr. Gayton was inclined to attribute their recent successes to

the practice of early and frequent removal of the tube, in order to permit of the extraction of membranes, and to the spraying of the wound with a mercurial solution. At the Heidelberg Hospital for Children Dr. v. Beck told me that their proportion of recoveries was 50 per cent. whilst neither of these precautions was in use. Great attention was however paid to the removal of membrane, and the employment of a suction bottle with a small rubber tube attached, which can be passed down the canula, very possibly in his hands serves the purpose which others attain by frequent removals of the latter. As has been so well and persistently urged by Mr. R. W. Parker, the removal of membranes, not only at the time of the operation, but as often as they may be re-formed, is the key-stone of the procedure. Without it tracheotomy is little more than a farce. To put trust in the canula as if the obstruction existed solely in the larynx, and all that was necessary is to secure an access to the trachea below it, is to lean on the weakest of reeds. It would be safer to dismiss the canula altogether, and to regard the operation simply as a means of gaining access to the trachea for the purpose of repeated removal of membrane.

At every hospital which I visited in Austria or in Germany I made inquiry as to the prevalence or otherwise of diphtheria, and as to the degree of success which attended its treatment by operation. At Munich, as I have already noted, intubation has wholly superseded tracheotomy; the same is the case at Budapest, where a total of three or four hundred cases treated by intubation with great success was mentioned to me. The more ardent advocates of intubation use it in the first instance in all cases, and resort to operation only when the child cannot bear the irritation of the tube; others use it only in selected cases. It has the obvious advantage that it may be adopted earlier in the case than tracheotomy would be held justifiable, but all will agree that it cannot be recommended as being on the whole easier of accomplishment in inexperienced hands than the latter. My inquiries in this matter procured me incidentally an interesting item of information respecting climatic and hereditary tendencies. Dr. Fiertz, who, practising in Zurich, has there had consider-

able experience in tracheotomy operations, assured me that it was definitely a more difficult procedure in native Swiss children than in strangers, on account of the all but universal prevalence in the former of enlargement of the thyroid. He said that this was always encountered in the operation, although there might be no evidence of bronchocele before commencing.

No. LXXVIII.—*International and Topographical Statistics of Prevalence of Disease.*

The collection of international and even of topographical statistics of disease appears to me well worthy of more attention than it has received. I will try to illustrate what I mean by referring to two or three subjects which my readers will find mentioned in different parts of the present number of ARCHIVES.

If, as many observers think, lupus is a very common disease in Bohemia and a rare one in Bavaria, whence comes the difference? First we have to ascertain the nature of the facts which lead to this conclusion and to estimate their degree and extent. This done it is obvious that a number of most interesting questions would arise in the course of our search for explanation. If it should come out that after all the prevalence of lupus is not in ratio with that of other tubercular affections, a not unimportant item of evidence as to its nature would be obtained.

Dr. Fiertz at Zurich, and Dr. Beckh at Nuremberg, both assure me that prurigo and pruriginous affections in general are extremely rare in their departments of practice. At Vienna they are reputed to be extremely common. Questions as to race, diet, clothing, cleanliness, etc., etc., at once suggest themselves in reference to the explanation of such a difference.

That ringworm is far less common in Switzerland, Austria, and Germany than it is in France and in England appears to be beyond doubt. We want, however, accurate statistics on this point, and for those of us who believe that alopecia areata is for the most part a sequel of ringworm, it is of almost crucial importance to ascertain whether the ratio of prevalence of the two is usually the same.

## DOCTRINAL PATHOLOGY.

DR. HIRSCH in his philosophical work on geographical pathology comes much nearer to a correct definition of erysipelas than most of our modern clinical writers. He at any rate avoids the blunder of considering it a specific fever. He writes: "I may define erysipelas to be an infective inflammation, disease of the skin, or of one of the mucous membranes near to the external surface of the body (mouth, throat, vagina, &c.), which in all probability proceeds invariably from a solution of continuity, or wound, and is characterised by its rapid extension over the surface, and by *the infective fever which accompanies the local process.*" Here we have a clear recognition of the fundamental fact that the fever is produced by the local inflammation, and not the reverse. The two weak points in the definition are the attaching undue importance to injury as an exciting cause, and the suggested exclusion of the mucous tracts where concealed from view. There is, I would suggest, not the slightest improbability in the belief that inflammation of the erysipelatous type may affect any mucous, or even serous, membrane, and may indeed originate in them. It is only because the skin and certain parts of the mucous tracts are exposed to view, and we therefore see erysipelas only on them, that we have got the idea that it is a disease to which they specially, or even exclusively, are liable.

I was once asked to see a gentleman upon whom another surgeon had operated for fistula ten days before, and who was believed to be about to die. I found him with his legs drawn up in bed, the whole abdomen extremely tender, and with high and varying temperatures. The operation wound was not in a healthy condition, but there was nothing resembling

erysipelas about it. We agreed to treat the case as one of peritonitis, and gave mercury and opium. Four or five days later erysipelas appeared about the wound and spread over the thighs and scrotum. About the same time the abdominal symptoms disappeared, and the treatment being changed for full doses of steel and quinine the patient rapidly recovered. My final interpretation of the case was that there had probably been present an erysipelatous inflammation of the bowels (whether of their mucous or serous coat might be hard to say), and that this had travelled downwards and finally appeared externally. No doubt it had originated from the wound, and the exceptional feature in the case is that it did not in an early stage attack the skin. It is, I think, not improbable that many deaths after abdominal operations are really due to internal erysipelas. Of this puerperal fever (peritonitis) is of course our best example.

Dr. Hirsch's limitation of the term erysipelas in the definition just quoted to inflammations beginning from wounds is, I conceive, a grave error. It leads at once to the exclusion of a large group of inflammations really erysipelatous in their nature. There is, I think, abundant proof that medical or idiopathic, and surgical or traumatic, erysipelas are the same malady and attended by the same microbe. That they are clinically transmutable, and that the one may originate the other, I cannot doubt. We have besides a large intermediate group, that in which inflammations of erysipelatoid type attack structures already the seat of disease but not recently injured. This we see occasionally around old ulcers, patches of eczema on lupus, but above all in cases of elephantiasis. Respecting the latter, Dr. Hirsch allows names to mislead his judgment. He writes respecting the so-called "wildfire of the legs," supposed to be common in Brazil, and counted as erysipelas: "The disease in these cases is clearly not erysipelas, but elephantine dermatitis (pachydermia)." The true interpretation of the phenomena of elephantiasis is, I believe, this. The disease in nine cases out of ten begins by an attack of erysipelas, due to contusion or some slight injury; the lymphangitis, which is the essential element of

all erysipelatous inflammation, leaves behind it chronic œdema, and it leaves also quiescent germs by which a like process is at intervals repeated over and over again. The elephantiasis condition results in fact from recurring attacks of erysipelas in a depending part prone to persisting œdema. The disease which I have been bold enough to name eczema-erysipelas has, I feel, increasingly a real clinical being. As a matter of mere conjecture, but with some probability, it may be supposed that in these affections the microbe of erysipelas meets the contagious material of eczema, and they mutually restrain and modify the action of each other. We have several varieties of eczema-erysipelas. One of the most definite—one of which I could produce twenty examples all exactly alike—is an affection to which adults past middle age are chiefly liable, and which attacks the face and causes the eyelids to swell just as in idiopathic erysipelas. It differs from the latter, however, in that it does not on disappearance leave the skin sound, but in a state of chronic eczema. Repeated attacks at longer or shorter intervals occur, and in many instances, after some years liability, the hands are affected also. The liability appears to be well-nigh irremediable. I have at present two ladies under observation, in both of whom I have watched the phenomena of the malady for several years without being able permanently to prevent them.

Are there any catarrhal forms of dermatitis? The answer to this question depends, of course, upon the definition which we decide to permit to the word catarrhal. For myself everything is catarrhal which is evoked by influences similar in kind to those which cause ordinary cold-catching, or catarrhal inflammation of the mucous membrane of the nose and throat. Cold in the head is the type of what is catarrhal, and nothing should come under that designation which does not, as regards its cause, course, and terminations, conform to parallel laws. The cause of a catarrhal inflammation is usually, perhaps always, the influence of cold and damp upon some part of the body's surface at greater or less distance from the part affected. The first effect is disturbed functions, an arrest, or more frequently a great increase, in the normal secretions. All catarrhal inflammations run their course and

tend to spontaneous termination, but all are very liable, after intervals more or less definite, to return. Some individuals are far more liable to catarrhal inflammations, and the proneness varies at different periods of life.

Keeping in mind the above statements we are in position to proceed, with some hope of success, to find an answer to the question proposed. If, on the other hand, we are content to regard as catarrhal everything which is chronic and presents a weeping surface, our terms will lack precision and our quest will end in confusion. Do such influences as commonly cause a cold in the head ever produce instead a transitory and subacute form of dermatitis? Are there individuals who instead of getting a running cold after exposure to damp get a sharp attack of inflammation of skin, and in whom this peculiar or erratic development of phenomena is often repeated?

The essential features of catarrhal inflammations (apart from their cause) are tendency to spontaneous recovery, completeness of disappearance, and proneness to recur after an interval.

Amongst the essential characters of eczematous inflammations is the proneness to persist indefinitely and become aggravated if not cured by art. Herpetic inflammations disappear spontaneously and are uninfluenced by art, but they very seldom recur, if we except those forms which are symptomatic, and which are often attendant on catarrh. Erysipelatous inflammations always disappear after a time, but their duration is indefinite, and they may be much influenced by art. They are very liable to recur after periods of health, and more especially when, as in the case of elephantoid hypertrophy and eczema-erysipelas, the tissues have never returned to a state of perfect integrity.

I have often wondered that no one has attempted to give a more systematic account of that very important subjective symptom, pain, than has as yet been done. Mr. Hilton's work, although having the word pain as part of its title, has but very fragmentary references to it as a symptom. What

we seem to need is a descriptive classification of the different kinds of pain, with reference to the various structures affected, and its special causes so far as they can be estimated. It may be alleged that this is an almost impossible task, since those who suffer pain are often far from skilful in their descriptions of it, or even in their attempts to locate it. Much, however, might I feel sure be effected by care and patience. We must select intelligent patients, and begin with well characterized and definite cases. The descriptions should, when possible, be obtained during the existence of pain, and not merely from memory. Unfortunately in many instances it may happen to the medical observer to have an opportunity of describing his own sensations. To give an instance of a typical kind of pain, I would mention that which attends the form of neuritis which produces herpes zoster. This should be discriminated from the pain, often yet more severe and frequently long persistent, which follows herpes. In the fact that herpetic neuritis may by disorganising a nerve cause it to become the seat of distressing pain for years afterwards, we have possibly a clue to the explanation of many other cases, in which pain is inexplicable and persistent. If we could attach more definite meaning to such words as burning, aching, stinging, throbbing, explosive, cutting, and the like, we should often gain more information than we do from our patients' narratives. Many patients will, if only we give them time and show that we are interested in what they tell us, use very expressive epithets in the description of their sensations.

# ARCHIVES OF SURGERY.

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JANUARY, 1893.

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## PEMPHIGUS DURING SECONDARY SYPHILIS

(two cases).

AN eruption deserving of the name of acute general pemphigus, during the course of syphilis, is in my experience one of the very rarest events. The two cases which I am about to record are by far the best examples of it which I have ever seen. They were both under observation during the same year. In several features they are close parallels to each other. In both, the use of specifics in the early stages of the disease had been neglected. In both, the patients were at one period so ill that a fatal issue was feared. In both, iodides appeared to do definite injury; indeed it may almost be said that in both there is a possible fallacy as to whether the pemphigus was really syphilitic, in that it may possibly have been caused by the iodides. In both cases arsenic appeared to exert a specific power over the pemphigus, just as it does in the non-syphilitic form, and both were finally cured by it. We have here again, however, the fallacy that it may possibly have been the leaving off of the iodides, as much as the use of the arsenic, which was beneficial. In both cases mercury was well borne, but did not cure the pemphigus until arsenic was given along with it. In both cases it seemed that the arsenic did much more good when it was given alone

concurrently with mercury, but not in combination with it. Thus it will be seen that in addition to their interest as examples of a very rare form of syphilitic eruption, the cases convey most important lessons in therapeutics.

A bullous eruption which ends in ulceration and in the production of the limpet-shell crusts of rupia, is of course not uncommon in syphilis. It occurs usually rather late amongst the secondary symptoms, and it may in some instances, from the size and persistence of the bullæ, seem to approach a condition of pemphigus. It is, however, a totally different eruption from that now under consideration. Its difference is shown in its tendency to produce the conical crusts, and in its far less acute and extensive outbreak. The character of the scar left is also quite dissimilar. Rupia leaves indelible, and rather deep, shilling-like scars, whilst in the present cases the scars were very superficial and ill-marked, being, in fact, pigmented stains rather than true scars.

In reference to the possibility that iodide of potassium was the cause of the bullous part of the eruption, I must explain that it was not known exactly what had been given in the early part of the disease in either case. I am not in a position to assert in either that iodides had been given before this feature in the eruption was assumed, but in both it is possible. During the later stages of the disease it is beyond doubt that, on several occasions, and in both cases, the addition of iodides to the prescription greatly aggravated the eruption. In case II., in fact, on at least two occasions, bullæ were produced, by the addition of iodide, after they had ceased to appear. We did not at first suspect the iodide, and it will easily be seen that cases of such severity, attended with such great cachexia, were exactly those to tempt us to disuse mercury and to substitute the iodide. It was not indeed till near the conclusion of both cases, and when I compared the notes of the two together, that the suspicion became strong that the iodide might have been actively injurious.

I have displayed both cases in Schedules constructed on "the space-for-time method," believing that it will best enable the reader to grasp the details.

**CASE I.**—*An indurated chancre. An eruption resembling varicella in third month. Eruption bullous on limbs and erythematous on trunk. Mercurial treatment. Imperfect cure. Persistence of eruption, pemphigoid and rupial, in spite of ptyalism. Apparent increase of eruption from iodide. Severe cachexia. Recovery under Arsenic and Mercury after a year's illness.*

DATE.	DETAILS.
1891	
August <i>Second month.</i>	An indurated chancre. No special treatment. A copious eruption appeared, which on the limbs "exactly resembled chicken-pox." No mercurial treatment as yet.
September <i>Third month.</i>	(First seen by me.) His limbs were covered with bullæ. (Portrait taken.) On the trunk the eruption erythematous only, copious on the back. A very hard chancre and bullet glands in groin still present. Mercury commenced. Sores in tousils and under tongue.
October <i>Fourth month.</i>	Mercurial treatment (but not under my own observation). A grain and a half of grey powder six times a day.
November <i>Fifth month.</i>	Mercurial treatment. The same pill. Eruption still persisting. Not under my observation. Iodides used at times.
December <i>Sixth month.</i>	Mercurial treatment. Eruption still persisting. I heard of him by letter, but did not see him. "In a pitiable condition." Mercury left off, and iodide of potassium in ten-grain doses substituted.
January <i>Seventh month.</i>	The eruption did not improve under the iodide, and the mercurial pills were, after a fortnight's intermission, resumed four times a day. Subsequently the iodide with bark given together with mercury.
February <i>Eighth month.</i>	The iodide made him sick, and the eruption was worse. It was left off. Under mercury alone he much improved, and the eruption almost disappeared.
March <i>Ninth month.</i>	Mercurial treatment and slight ptyalism. Much better, but unable to sleep and troubled with night sweats.
April <i>Tenth month.</i>	Seen by me for the second time on 7th. Emaciated and weak, covered by a pemphigoid eruption, affecting limbs chiefly, but trunk also. I suggested iodide. It appeared to bring out more bullæ, and he became so weak that he was confined to bed.
May <i>Eleventh month.</i>	Very ill. Still taking both iodide and mercury, but in combination with arsenic. No fresh bullæ; Ptyalism. It is certain that the arsenic has prevented the development of new bullæ.
June <i>Twelfth month.</i>	Improving, but only very slowly, and the eruption still persisting. Emaciated. Fresh bullæ occasionally.
July <i>Thirteenth month.</i>	Mercury and arsenic given separately, but at same time iodide left off. Immediate improvement.
August <i>Fourteenth month.</i>	On the 19th he had not for a fortnight had a single fresh pemphigus bleb. Much better in all respects.
September <i>Fifteenth month.</i>	Improving in all respects. Gaining flesh. Surface of trunk covered with superficial scars and dark stains.
October <i>Sixteenth month.</i>	Has returned to his work after a year's severe illness, and is strong and well. Free from eruption. (Subsequently some tendency to return of pemphigus.)

*Case I.* (see preceding Schedule).—When I first saw this case, the arms and legs were covered with pemphigus of such a marked character that I at once had a portrait executed for the College of Surgeons Collection. It may now be seen there. Up to this time the man had not had any skilled treatment. He still had the remains of his chancre, and some very hard glands in his groins.

Mr. George Stevenson, who brought the man to me, had diagnosed syphilis, and had just begun mercurial treatment, but until within a few days of our consultation the man had had no good advice, and had taken no mercury. A remarkable feature was that the eruption was bullous on the extremities but only erythematous on the trunk. It was abundant on the back, but less so on the abdomen. The bullæ presented every gradation in size from varicella-like vesicles to that of half a billiard ball. There was a good deal of erythematous swelling of the skin beneath the bullæ. Mr. Stevenson told me that the eruption had in its first stage looked exactly like chicken-pox. The evening temperatures had been 100. There were superficial sores in the tonsils and under the tongue.

We prescribed mercury. He took the Hydr. *cm* Cret. in doses of a grain and a half, with a little opium, six times a day for about two months, and then for a short time eight times a day. He was better, but not well. On December 30, as he was very weak and the eruption still persisted, mercury was laid aside, and iodide of potassium in ten-grain doses in sarsaparilla substituted.\* This did not seem to agree. The eruption increased and mercury was again resorted to. During January, under mercury alone he improved. The iodide was again given for a fortnight in conjunction with mercury, and he seemed worse for it. Towards the end of January, under mercury alone he got almost well. Subsequently he became very weak, had night perspirations, and although his gums were spongy the eruption persisted. Iron and strychnia were now tried, and again the iodide was given. Again, however, he relapsed, and mercury had to be again resorted to.

\* I am not sure that he had not taken some iodide with the mercury before this date.

This patient lived in the country, and he passed from under the observation of Mr. Stevenson as well as myself. I did not see him again for seven months. During the latter part of this time he had been skilfully watched by a practitioner in the country.\* Our first consultation had been on Sept. 9, 1891, and the second was on April 7, 1892.

On this latter date he came to me in a wretched state. He had lost flesh and colour, and although slightly salivated was still covered from head to foot with eruption. His limbs were still much more severely affected than the body, but the trunk did not escape. The hands were wholly free, the vesication ending abruptly at the wrists. There were numerous superficial scars. Many of the sores had low crusts, but they did not approach the limpet-shell form. There were but few well-formed bullæ, not nearly so many as on the former occasion.

From April to August I saw him once in six weeks, and we persevered with a mixed treatment of mercury, arsenic, and occasionally iodides. He continued very weak, and the eruption still persisted. The bullæ were smaller and less persistent than they had formerly been, and more crusts were formed. He was still in a deplorable condition.

On July 13, guided by my concurrent experience of Case II., I made the change which effected the cure. It consisted in the use of mercury and arsenic in separate doses. He took a grain and a half of grey powder with a little opium, and four minims of Pearson's solution in a mixture at the same time, four times a day. He began to improve directly, and on August 19th I was able to record that no fresh bullæ had appeared for a fortnight. He was then slightly salivated. After that his progress, though slow, was steady. At the present date he is well and fairly strong, and after his fourteen months' severe illness has resumed his work as a butcher. He is covered with dark stains and superficial scars.

\* I believe that during most of this time he took iodides more or less.

CASE II.—*Syphilis imperfectly treated during five months. Lichenoid eruption, which subsequently became vesicular. An attack of facial erysipelas nearly fatal. Albuminuria. Acute iritis. Specific treatment commenced in fifth month. Great emaciation and a well-marked pemphigus eruption. Definite benefit from Arsenic and Mercury. Iodides injurious. (Patient, a barber, aged 56.)*

DATE.	DETAILS.
September <i>Second month.</i>	The sore appeared (one month after contagion). He denied exposure, was believed, and no diagnosis was made.
October <i>Third month.</i>	The sore is said to have been phagedenic, and caustic was used. An eruption appeared.
November <i>Fourth month.</i>	Details of treatment not known. Very ill, with copious eruption.
December <i>Fifth month.</i>	Was made to take very hot baths. No diagnosis of syphilis.
January <i>Sixth month.</i>	A severe febrile illness. Temp. 104 repeatedly. Albumen in urine. On Jan. 10th the eruption was partly squamous and partly bullous. Bullæ quarter of inch in diameter, with no inflammation.
February <i>Seventh month.</i>	12. Was seen by my son, and syphilis first recognised. Liq. Hydr. in drachm doses given. He was covered with a lichenoid and papular eruption. 24. Acute iritis in right eye. Skin absolutely covered by a mixed eruption, papular, bullous, and lichenoid.
March <i>Eighth month.</i>	I ordered increase of mercury, with seven grains of iodide. On the 9th I ordered Liq. Hydr. ʒj, with cinchona and arsenic. On the 14th I visited him at his own house, and found him exceedingly ill and covered with pemphigus. Ordered to omit iodides and take arsenic and mercury separately.
April <i>Ninth month.</i>	21. His eruption was wholly gone. 26. He came to my house covered with stains and scars, but wholly free from eruption.
May <i>Tenth month.</i>	Is taking four-minim doses of Fowler's solution with mercury in pill. Is quite free from eruption.

After the last note he remained quite free from eruption. He had some nervous symptoms which induced us to discontinue the arsenic, and he took mercury only. He is now quite well.

The subject of Case I. was a healthy man of about 35. That of Case II., a barber by occupation, was older, being nearly 56. Although not robust, he had shown no special signs of failing health until the syphilis. I shall in this instance content myself with the schedule form of narrative, and will merely remark that the pemphigus character of eruption was most definitely marked. When I saw the patient on the 14th of March he was covered by large bullæ, which presented no feature of difference from those seen in the worst cases of the non-specific form.

Idiosyncrasy on the part of the patient is the only explanation which can be offered of these erratic forms of syphilitic eruption. It will be seen that in both these patients the peculiarity involved not only susceptibility to special influence from the syphilitic virus but also from the iodides. About the latter fact there could be no doubt, although I do not really believe that in either the iodide actually caused the eruption to assume a bullous type, yet in both it most certainly aggravated it.

Although pemphigus is so rare as a secondary eruption in acquired syphilis, yet we may remember that it occurs under exceedingly peculiar conditions in infants inheriting taint. In them it is almost always the precursor of speedy death, and is seen, contrary to rule, within a week of birth, or may even be present from the first day. It is also usually limited to the hands and feet, parts which were exempt in the cases I have narrated.

## POST-MARITAL AMBLYOPIA (BURNS' AMAUROSIS).

"Mr. Burns" was a young lawyer, who was in May, 1874, apparently in good health, and only a few weeks married. He was brought to me so nearly blind that he could but just see letters of 200 at six feet. On use of the ophthalmoscope, nothing was discovered. He had no other nervous symptoms, excepting a little headache. He was a man of temperate habits and sound health. The failure of sight had developed rapidly in the course of about ten days. I insisted on abstention from sexual intercourse, and gave tonics with mercury. In a few months he was quite well. He has ever since enjoyed good health and perfect sight, and intercourse in moderation has now no injurious influence on him. I have seen him quite recently, after an interval of sixteen years from his attack of amblyopia.

In the Lecture\* from which I abstract the above case, I have narrated another, the particulars of which I had from its subject long after his illness. A gentleman in strong health, and the father of a large family, told me that in early youth he had been brought by his father to a London oculist, because he was almost blind. He assured me that the only cause of his condition was that he had been allowed, as being but a boy, to sleep in the same room with a servant girl, who used to persuade him to have intercourse with her. On his being taken away from the company of this girl, his sight returned, and it never afterwards failed in the least.

A third example of this form of amblyopia, and also of complete and permanent recovery both of sight and health, has quite recently presented itself.

\* Mr. Burns' case is recorded in a lecture delivered by me in 1876 at the Moorfields Hospital, and published in Vol. IX. of the Reports, page 10. I am glad now, after an interval of sixteen years, to be able to complete it.

A married man of 32, in robust health, gave me the following history of what had happened to him in early life. At the age of 18 he fell suddenly into dissolute habits, and indulged to great excess in sexual intercourse. He smoked also. The failure of his sight developed rapidly from a "dull haze before me" to complete blindness. "I was quite blind," he said, "for three weeks." "Could you have seen your hand held before you?" "No, nothing." Several surgeons were consulted, and ultimately Mr. George Critchett, who used the ophthalmoscope. There was question whether it was due to syphilis, but Mr. Critchett said that it was "solely of nervous origin, and due to exhaustion from excess." He had, in reality, never had syphilis. After about three weeks' blindness the sight returned, and it has ever since been excellent. Mr. — has, during the fourteen years which have since elapsed, led a very energetic life, engaging in exploring and wild sports, and he has never experienced the slightest failure of any nerve function. He has now been married for six years, and reports that he is in all respects "strong." He has the appearance of being so. I examined his eyes with the ophthalmoscope, and found the discs florid and in every way normal.

These three cases, so remarkably alike in their features, might lead us to believe that post-marital amblyopia is, like that due to smoking, usually recovered from, and that no relapse occurs although sexual indulgence is resumed. Recovery and freedom from relapse are very definite features in the best-marked examples of tobacco amblyopia. The failure of function which I am now describing, has, indeed, remarkable features of similarity with that due to tobacco. It differs from it chiefly in being much more rapid in its development, and in passing to a much higher degree of amblyopia. Tobacco cases usually require months to develop, and rarely proceed to any condition approaching blindness. They recover also much more slowly than do these post-marital cases. As regards recovery, it may be remarked that there are possibly in both series a few cases in which the disease advances to complete and permanent blindness. It

may be conjectured that this may happen in cases in which the cause is never suspected and never removed. The cases under notice are not, as a rule, attended by any failure of sexual power, nor are the tobacco cases attended by any distaste for smoking, or consciousness on the part of the patient that it is injuring him. It might be difficult, perhaps, in the case of tobacco amblyopia to produce any cases of permanent and complete blindness which should be beyond doubt as to correctness of diagnosis. I am sure, however, that I have seen a few which were probably such. That they are very exceptional to rule, all will admit. It is the same with the amblyopia now under discussion. Recovery is certainly the rule. Mr. Travers has recorded a case in which a robust farm lad became the favoured paramour of two girls, his fellow-servants. "Gutta serena," presumably permanent, was the result within a twelvemonth. I have myself seen one patient, a healthy young married man, whose sight began to fail a few weeks after marriage, and in whom the condition advanced to absolute and, I believe, permanent blindness. When I saw him he had white discs, but was wholly free from other symptoms of disease of the nervous system. Neither in Mr. Travers' case nor my own can the sequel of the case be given, and it is obvious that with this omission the diagnosis is open to doubt. Organic disease of the brain does not always disclose itself early.

The cases which I have narrated suffice, I think, to show that young men who have recently assumed habits of frequent sexual indulgence (whether in marriage or otherwise does not matter), are liable to have their sight fail rapidly, without other symptoms. The "blindness" resulting from this cause is usually only transitory, and the recovery is complete and without liability to relapse. Inasmuch as this form of amblyopia presents well-marked peculiarities, necessitates a peculiar treatment, and justifies a special prognosis, it will, I think, be convenient to recognise it under a definite name, and I venture to propose that it be called "After-marriage Amblyopia (the Burns type)." I would rigidly exclude from the group all cases in which the cause is doubtful.

*Vere scire est per causas scire*, and I should like to insist

that, although other cases in association with other not wholly dissimilar causes may perhaps be found, yet that it is desirable to keep the groups separate. I have above pointed out post-marital amaurosis has features of resemblance to tobacco amaurosis, and it may perhaps be the case that the failure of sight sometimes observed after parturition is similar in kind. I would, however, any rate for the present, keep these all in special groups. Rapidly produced and all but complete blindness, without visible changes, and with the possibility of rapid and complete recovery, are the main features of all.

The habit of masturbation and great excess in sexual indulgence under any circumstances, may each in turn, I feel sure, induce failure of sight, and derange the nutrition of the eyeball. The post-marital form of amaurosis is, however, quite distinct, and never, I believe, occurs excepting to those who have been newly placed under conditions tempting to excessive indulgence. Under the other circumstances the failure of sight is very gradual and usually permanent, and is attended by symptoms of general neurasthenia. In the Burns' type it is sudden, and stands alone.

## BARTOS' DISEASE (ALIBERT'S PIAN RUBOÏDE).

I would venture to suggest that the case which is the subject of Plate XXXV. in the beautiful atlas of Alibert, and which he names Pian Ruboïde; should be known, temporarily at any rate, as Bartos' disease. Bartos was the name of the patient, and he has been fifty years in his grave. The case is a very peculiar one, and, with the exception of histological facts, it is complete. We have the patient's history, an excellent portrait, and a full narrative of the post-mortem. The facts were briefly these: A healthy married man, aged 30, a thrasher, died of exhaustion after an illness which had lasted not more than a year, possibly not more than six months. The dates are a little uncertain. This illness had commenced by the formation of little raspberry-like growths on the lips, which had been followed by similar growths over the whole of his scalp, over the pubes, and some other parts. He had continual coryza, and became emaciated and very weak. The portrait shows the back of his head, covered with florid papillary growths; the patches are as large as the palm of the hand, and their surface much resembles cauliflower buds. So far as the narrative goes there was no gland disease. At the post-mortem some small swellings which contained pus were found about the larynx.

What was Bartos' malady? Certainly it ought not to be hastily assigned to the group of granuloma fungoides. For if it were so, it would certainly be put with others essentially different from it. Clearly the disease was an infective one, and the original sore on the lip was very probably acquired by contagion. In some features it much resembles a case recently published by Dr. Prince Morrow, and named by him Tuberculosis Papillomatosa Cutis. Or, was the case one allied

to pemphigus vegetans? Is it even possible that it had anything to do with chronic farcy? It is not possible to answer any of these questions definitely, and the wisest course seems, to me, to let the case for the present stand by itself, giving to it a definite name by which dermatologists and others interested in the subject may remember it, and keeping clearly in memory the portrait by which Alibert has illustrated it. To continue the name Pian Ruboïde would be, I fear, to perpetuate the risk of error, by suggesting that the case has real relationships, which it probably has not, with other maladies which have been named pian. Better, I think, to know the disease by the wholly colourless name of the man who was its subject.

In illustration of the superior propriety of employing the name of the patient, I may mention that Alibert's portrait has been copied in another atlas with a wholly different pathological name attached to it. Not improbably it has been referred to by other authors, and as often re-christened. If we keep to the patient's name, we shall at any rate know what case we mean and what its clinical features were. So far as the affection of the skin of the scalp goes, a few more or less similar cases might be cited. I possess a portrait of at least one such. I do not, however, know of any in which the whole history of the case was parallel with that of Bartos, nor any in which a fatal cachexia resulted.\* I shall be much gratified if any of my readers can direct my attention to any such.

\* The portrait of "Sycosis Frambæsiformis," which is given in one of Hebra's plates, represents the back of the head of a man with a pustular and furunculoid eruption on the nape of his neck. The back of the hairy scalp shows a large patch covered with florid papillary outgrowths very similar to those in Alibert's portrait of Bartos' case. Unfortunately I have not found any history of this individual patient, and there is no reason to suspect that it was a case which ended fatally.

Under the name of "Elephantiasis affecting the scalp and other parts," Dr. Thomas Goodfellow, who was at the time a house physician of the Manchester Royal Infirmary, recorded in the *Illustrated Medical News* the case of a man named James S—, *æt.* 51, in whom the conditions as delineated appear to have much resembled those of Bartos'. It is also stated that the man was ill, and had sores on his face.

## NOTES ON DIPHTHERIA.

It is not possible, if my views as to the nature of the disease are correct, to construct any accurate statistics as to the ratio of fatality from diphtheria. We are dealing with a name to which it is not practicable to give any precise limitary definition. No one can say where inflammatory sore throat ends and "diphtheria" begins. One observer might legitimately count all cases of sore throat occurring in a household in which there were any definite cases of the diphtheritic type as belonging to that category. He would probably be quite correct in doing so, but clearly his statistics of ratio of fatality would be much better than those of another observer who used the name only when definite and considerable formation of membranes took place. We can at the best produce fragmentary or, in some instances, little better than anecdotal statistics. In what I have previously written on this subject, I have dealt with it somewhat after this fashion, and I confess I am not without a hope that it is possible in this way to create impressions which shall be quite as truthful as those based on more extended numerical calculations.

It may perhaps be as well to state at once that I am concerned to uphold the following propositions:—

First, that the name "diphtheria" is applicable not to a specific fever, but to the consequences of a local inflammation which affects usually, but by no means invariably, the throat and air passages.

Second, that diphtheritic inflammations may be induced by cold-catching, and that when so induced they may become, as ordinary colds often do, contagious to other persons.

Third, that there is no difference in nature between croup and diphtheria, excepting that in the latter malady the inflammation has developed in high degree its contagious properties.

Fourth, that it is probable that a diphtheritic inflammation which has itself originated by contagion becomes, on that account, far more contagious than one which has been developed in connection with taking cold.

Fifth, that the spread of diphtheria in epidemics, in hospitals and in families, is to be wholly accounted for under the known laws of contagion, and that it is not probable that local conditions, such as defective drainage, &c., apart from exposure to cold and damp, take any material share in its production.

Sixth, that the laws of idiosyncrasy are very influential in reference to the severity of diphtheritic inflammation. Certainly some persons and some families are remarkably prone to suffer.

Lastly, as already implied, it is not possible to mention any one symptom or sequela which is characteristic of diphtheria. Thus the presence of membranes is certainly not invariable (perhaps if we count all the cases occurring in an epidemic it may be even exceptional), and the sequela of paralysis may occur in some cases of sore throat which have no claim to be called diphtheritic.

I will now proceed to mention, without much attempt at classification, the items of evidence which incline me to a firm belief in the propositions above stated.

#### *A Rural Epidemic of Diphtheria.*

About fifteen years ago I had the opportunity of observing for myself the facts as regards a village epidemic. The village, I may say, is an extremely healthy one, very straggling, and having many houses separated from each other by distances of a quarter to half a mile. Regarding most of the houses there is nothing whatever to be alleged against their drainage or water supply. Most of them are dependent on their own wells for water, and, as regards milk, it is from very various sources. The epidemic began in the central part of the village, and amongst school-children. Several deaths occurred in the course of a few weeks, a sanitary committee was formed, and the school was closed. After this the epidemic sore throat spread, I believe, to almost every house

in the neighbourhood, without any regard to rich or poor. I myself saw many of the patients, and some of them occurred in my own family, and others in those of near relatives. The total number of cases was not large, since the district is thinly populated, but of children I believe very few escaped. No case of death came under my own notice after the first two or three weeks of the outbreak, but several patients were extremely ill; many had abundant membrane-formations, and three or four cases of paralysis followed. Now whilst this was going on I examined repeatedly the throats of those who were suffering slightly. In some of these there was congestion only, no trace of pellicle; and in two or three some little strips of pellicle were observable for a day or two, and nothing more. The slightest cases were, as usual, in adults, and the most severe in children. The facts which came under my own eyes in this little epidemic are, I believe, with the exception of the early cessation of fatality, exactly what are usually seen in others. I have conversed with very many medical men in all parts of the country, and have endeavoured to collect their experience, and as a result feel quite justified in believing that when diphtheria is prevalent, there are commonly a great many sore throats due to its contagion which never show what are supposed to be its characteristics. I may add, in reference to the district which I have alluded to, that we have had, both before and since the little epidemic described, occasional cases of "diphtheria" and "croup," and that I have heard now and then of several children in a family suffering from sore throats which were presumably contagious. Many medical men resident in country districts have assured me that they were quite cognisant of similar facts, and that in an isolated farmhouse it might not infrequently happen that a sore throat would run through the family, concerning which it was impossible to be sure whether it should be called diphtheria or not. My inference from this is that the type of diphtheria may vary very much in different cases, that it is capable of originating in all localities and in all classes, and that it is only now and then that its contagious virulence becomes highly developed.

*On the Real Nature of Diphtheritic Paralysis.*

It is very important that we should entertain clear ideas as to the probable nature of the forms of paralysis which are often a sequel of diphtheria, and which constitute such a remarkable feature. We must not assume vaguely that they are any proof of blood-poisoning, far less that they necessarily denote a specific fever. In all probability they are purely local in origin, and are due to an ascending neuritis which starts from the nerve-endings in the affected mucous membrane. In this feature they have probably their analogues in a number of other diseases. Infective inflammations of skin and mucous membrane are liable always to result in the implication of the end-organs of the nervous system, and from them to travel upwards along the nerve trunks. Beginning as an affection of sensory structures only, they may, on meeting, by ascent along a sensory nerve-trunk, with motor-trunks or nuclei, implicate the muscular system. This is exactly what we observe in the neuritis of leprosy. In this disease the skin is invariably the part first affected. Its sensory structures are destroyed or greatly impaired by a chronic inflammatory action, and local numbness is the result. At this stage, however, another complication may occur, although it is very far from being invariable. The inflammation may travel upwards along the sensory filaments, and when these, in the case of mixed nerves, join with their motor companions, may by implication of the united trunk produce paralysis of definite groups of muscles. Examples of this are constantly seen in leprosy. It is, I think, exactly the same in diphtheria. Defects in sensation of the mucous membrane which has been involved are constantly present after severe attacks of the diphtheritic throat. When the membrane has cleared away, the patient will allow the pharynx to be touched without displaying any signs of irritability. In a large majority of cases this condition of partial anæsthesia gradually passes off, and no further complications ensue. This is just what is observed in the majority of cases of leprosic erythema. In a few cases of diphtheria, however, the process referred to, of ascending

neuritis sets in, and the proof that it has done so is afforded by the implication of certain groups of muscles, or even by a general limb-paralysis.

My own experience of post-diphtheritic muscular affections has been not inconsiderable in connection with affections of the eye. Next to paralysis of the pharyngeal muscles, and indeed in some cases when these latter have been but slightly or only for a short time affected, we have the implication of that part of the third nerve which is concerned in accommodation. The patients, who are apparently quite well, make their appearance at the ophthalmic hospitals or in our consulting rooms complaining that they are losing their sight, and have become unable to read. On examination it is found that a convex spectacle-glass entirely restores the reading power, the defect being due simply to loss of accommodation. None of the other third nerve muscles as a rule suffer. There is almost always the history of the patient having been troubled by fluids escaping by the nose. I have seen some cases of this paralysis of accommodation after very slight attacks of diphtheria, and a few in cases of quinsy or pharyngeal abscess, where presumably no real diphtheritis had been present.\*

In all cases the condition after a few weeks' duration passes off, and this, I think, quite irrespective of any special measures of treatment which may have been adopted; nor have I ever met with cases in which relapses have occurred. The more severe and extensive forms of paralysis are far less common than the mild ones, but they obey the same law as regards being transitory and recoverable, provided only that the patient can be kept alive.

*On the Non-Association of Diphtheria with Scarlet Fever.*

In reference to the supposed association between scarlet fever and diphtheria, it may be asserted that the facts prove

\* Dr. Mansel Sympson, in his interesting account of diphtheria as he observed it in Dr. Gee's wards in St. Bartholomew's, has the following important observation which fits well with the opinions I have expressed: "In epidemics, catarrhal diphtheria may occur wherein there is no formation of false membrane whatever. These cases may communicate diphtheria to others and may be followed by paralysis."

nothing more than that the one malady does not save from the other. Statistics might be quoted from all hands in proof that the two diseases do not show any tendency to prevail together.\* Scarlet fever epidemics are not productive of epidemics of diphtheria. Yet coincidences of the two may not infrequently be observed, and it is quite possible that the scarlet fever sore throat may occasionally be attended by the formation of membrane. The experience of the metropolitan hospitals during 1890, with a total of nearly 37,000 scarlet fever cases, shows that only about two per cent. suffered from any form of throat ailment which could have been suspected to be diphtheritic. It must be remembered also that these cases occurred during the prevalence of diphtheria in London, and in the hospitals into which diphtheria cases were admitted. In the Eastern Hospital during 1891, out of nearly 1,000 scarlet fever cases, eight developed chicken-pox, two measles, two whooping cough, and only one diphtheria.†

*“Croup” a complication of Diphtheria.*

As regards the use of the terms “diphtheria” and “croup,” I observe that it is becoming the custom with many to give the former name only to cases attended with stridulous breathing and other definite symptoms of laryngeal obstruction. Thus “croup” becomes a complication or an occasional accompaniment of diphtheria.‡ In this sense the word is used in the Reports of the Asylums Boards. Thus on page 13 in that for 1890, I find it stated that albuminuria occurred in 14 per cent. of the total number of diphtheria cases; paralysis general or local in 12 per cent. ;

\* See ARCHIVES for October, 1892, p. 143.

† In reference to the influence of cold, &c., in causing sore throats, I am glad to observe that Dr. Hume, superintendent of the Northern Hospital, Winchmore Hill, insists on the importance of tar-paving for the courts. During the year no fewer than eleven cases of diphtheria had supervened in the convalescent patients under his charge, and he writes that he regards the “combinations of cold and damp as a potent predisposing agent to throat disease.” For myself, I would rather write “efficient agent.”

‡ It may be admitted that scarlet fever convalescents are prone to take diphtheria if exposed to its contagion. At the Northern Hospital, Winchmore Hill, during 1890, 2,611 cases of scarlet fever were admitted and 247 of

"CROUP" in 8 per cent.; rhinitis in about 7 per cent., and Adenitis in nearly 3 per cent. Here then we see that it is in only quite a small minority of diphtheritic cases, even of those severe ones which find their way to hospitals, that definite laryngeal obstruction occurs. It is, of course, in the latter only that the question of operation can come into consideration.

*"Closing" in Scotland a century and a half ago.*

The parish of Kilmarnock preserved during the last century, beginning with 1728 (the birth-year of John Hunter), a very interesting record of its mortality. This register, originally kept by the parish schoolmaster, Robert Montgomery, has been made the subject of a very valuable analysis by Dr. John McVail, and supplies a most instructive chapter in the social history of the large towns of Scotland. Croup and diphtheria were registered under the expressive name of "Closing," and the facts given prove that they had during the last century a very considerable prevalence, and further that, in conformity with more recent experience, their prevalence varied very much in different years. Thus in the six years, 1734-40, "Closing" had only five victims. During a similar period, 1740-46, the number rose to 29. From 1746-52 it was 30, from 1752 to 1758, 33, while from 1758-64 it was only 9, or not two in a year. Thus it appears highly probable that during the 18 years '40 to '58 diphtheria maintained an unusual degree of prevalence, and destroyed, in a population which was perhaps not much more than 4,000, more than five lives annually. Its average mortality was indeed considerably greater than that of measles, and five times that put down to cancer. It did not, however, quite touch that of whooping cough, and was only one-sixth that of small-pox.

diphtheria. No fewer than 38 of the scarlatina patients took diphtheria, and of these 24 died, a fatality of 63 per cent. At the Stockwell Hospital, in contrast, during the same year, 1,003 cases of scarlet fever were treated, and not a single case of diphtheria occurred. The explanation offered is, that only during the last three weeks of the year were any diphtheria cases taken in. So also at the Fulham Hospital, where 130 diphtheria patients were admitted, no fewer than 33 of the scarlet fever patients contracted the disease, and 25 of these died. It is quite clear from such facts that the most careful isolation of diphtheria patients ought always to be observed.

*Croup and Diphtheria in the London Fever Hospitals.*

I have before me the Reports for the years 1890 and '91 of the Statistics Committee and Medical Superintendants of the fever hospitals of London. Into these institutions all the cases of diphtheria, scarlet fever, measles, etc., needing isolation away from the patients' homes, are admitted. And although I must still protest that I am not attempting to construct statistics, it may, I think, be not difficult to extract from them some very important items of information.

*Tracheotomy in the London Fever Hospitals.*

In the year 1891, the operation of tracheotomy was performed in the Eastern Hospital in 82 cases, and of these only 19 recovered. Sixty-eight of these patients had been admitted as diphtheria, and of these 18 recovered, while 10 were admitted with scarlet fever, which afterwards developed diphtheria, and of these only one recovered. Two were in cases where scarlet fever was followed by measles and diphtheria, and two were cases in which diphtheria had followed measles, and all these four died. In 25 of these operations it was resorted to immediately after the patient was admitted into the hospital, but in a stage which was almost hopeless.

In the New Cross Hospital, in the year 1890, twelve tracheotomies were done with one recovery, and intubation resorted to in sixteen cases with two recoveries.

*Facts as to Contagion.*

In evidence of the contagiousness of diphtheria, and at the same time of its usually non-fatal character in adults, it may be mentioned that Dr. Caiger, medical superintendent of the South-Western Hospital, reported for 1891 that seven of his officials had contracted diphtheria, presumably from their patients. All were adults, and all recovered.

*Fatality from Diphtheria.*

The mortality of 201 admissions into the Stockwell Hospital in 1891 was nearly 24 per cent. In the South-Eastern

Hospital the mortality was as high as 47 per cent. A very noteworthy fact in connection with this high mortality is that only one death occurred in a patient over ten years of age.

Dr. Bruce in the Western Hospital during 1891 recorded a mortality of 54 out of 151 cases of diphtheria, being at the rate of 38.4 per cent. In the previous year it had been only 22.

Concerning the New Cross Hospital, Dr. MacCombie records that during the year 1890 "one assistant nurse and one laundry-maid contracted diphtheria, and both died. Thirty officers were warded with tonsillitis." This statement well illustrates what has been said as to the impossibility of constructing diphtheria statistics. Those who (with myself) would feel unable to say of any case of tonsillitis occurring in a diphtheria ward that it was not the result of contagion, might incline to class these thirty cases as diphtheria, and to give a fatality of one in fifteen; whilst on the hypothesis that these were not diphtheria, the fatality rises to a hundred per cent.

*Note on the prevalence of Croup in Scotland and Yorkshire  
a century ago.*

In a letter from Dr. William Buchan to Mr. William Smellie (written at Sheffield, 1764) the following occurs: "I cannot make out from your account whether Dr. Hume's pamphlet on the Croup is wrote in Latin or English. If in the former, I think *suffocatio Stridula* a very proper name: but if he translates that into *Croup* he may keep his pamphlet at home; for I have never met with any one in England, either medical people or others, who called the disease by that name. Though that disease is very common here, yet should one speak of the Croup to a Yorkshireman he would believe you either meant the rump (crop?) of a fowl, or the buttocks of a horse. The disease is, however, by no means sufficiently understood; and I should be extremely glad to be possessed of any good performance on the subject. Betwixt you and I, it does not matter a pin what name any man gives a disorder provided he points out the symptoms accurately, and proposes a rational method of cure."

I quote the above not solely on account of its philological bearing, but because it gives testimony to the prevalence of croupal affections in former times and the interest they excited. That large epidemics have been more prevalent and more fatal during the last half-century seems certain, but the more I have read in the writings of older observers, the more strongly I have become convinced that croup and diphtheria have prevailed as far back as medical history will take us, and they presented the same general features as at present.

*Proclivity to common Catarrh ending at length in fatal Croup.*

Auvert gives, in his magnificent Atlas, a delineation of membranous laryngitis from an adult. His patient is thus described:—"Vix quadraginta quinque annorum. Debilis et lymphaticæ constitutionis. Ex minimo afflatu aeris frigidi sæpe tussis catarrhalis symptomatis obnoxius."

The fatal attack of laryngitis, after which the specimen was obtained, was caused by exposure when insufficiently clothed. He died asphyxiated on the fourth day.

I give this extract and reference with much satisfaction because it supports, in the clearest possible manner, two of the statements which I am concerned to defend. In the first place it shows that the laryngitis of adults is membranous in exactly the same sense that "Croup" is so in children. In the second it affords an instance of a middle-aged man, who had long been liable to take cold easily and to have a catarrhal cough when he did take cold, finally becoming the subject of membranous croup. This last attack was induced by the usual cause, exposure to cold, and it probably differed from previous ones only in the greater degree of severity. I hold it to be a most important proposition that catarrhal inflammations may end in croupal ones.\* Items of clinical evidence supplied, as in the case of Auvert's Plate, incidentally, and without any attempt to uphold a theory, are very valuable.

I have already mentioned several facts in proof that

\* Dr. Mansel Sympton records of one of his cases, a child of 5, "for a week had a husky cold," and of another, "had a strangling cough and was sick" five days before admission. See p. 13.

diphtheria is often preceded by symptoms like those of a common throat cold. Statements of this kind may be found in almost every writer. They are of the utmost importance in reference to our creed as to the origin of the malady.

*A House-Epidemic—Sudden death during convalescence.*

The following letter, which I extract from the biography of William Smellie (the printer, not the doctor), affords evidence of the sameness of diphtheria in former days with what we observe at the present time. We see it prevailing as a family- or house-epidemic, spreading no doubt by contagion from one brother to the other. There is no reference to the disease being at the time prevalent in Edinburgh, and very probably it had begun in catarrh. Not the slightest attempt at isolation appears to have been attempted or even thought of. As an example of sudden death (from heart failure or embolism) during apparent convalescence from diphtheria, the narrative has also much interest. Exactly such deaths occur at the present time.

MR. WILLIAM SMELLIE TO MRS. MARIA RIDDELL.

“EDINBURGH, *February 19, 1795.*

“DEAR MADAM,—For several weeks past my family has been in a very sad condition. Five sons were all afflicted with dangerous sore throats. One of my sons, aged between nineteen and twenty, a good and useful young man, who from his cradle to his grave never vexed me, expired after an illness of five or six days. The rest, I hope, are in a state of convalescence.

“I am, &c.,

“WILLIAM SMELLIE.”

*Note appended by Editor of “Smellie’s Biography.”*

“The death of this promising youth was attended by the following particularly distressing circumstance. He had gone to bed at night with every appearance of being considerably better, and was considered as in a fair way of recovery. Henry Smellie, a younger brother, who lay in the same bed with Thomas, and was afflicted with the same

disease, thought proper towards morning to endeavour to awaken his brother, when, to his indescribable astonishment and horror, he discovered that Thomas lay dead beside him."

*(To be concluded.)*

[For some statements as to the operative treatment of diphtheria in Dublin, see ARCHIVES, Vol. IV., p. 20. For facts from Nuremberg and Munich, pp. 133 and 142 of same.]

## NOTES FROM CONGRESSES AND CONTINENTAL HOSPITALS.

(Continued from page 145.)

### *A Case of Acute Lupus Erythematosus (with Erysipelas).*

IN a small, special ward under the care of Professor Schwimmer, in the Budapest General Hospital, my attention was especially called to the case of a poor woman who had been admitted a week or two before. She was about the age of thirty, and appeared to be very ill. We were told that her temperatures were variable, but usually high. In addition to Professor Schwimmer himself there were present at the consultation, MM. Hardy, Vidal, and Hallopeau, representing the St. Louis Hospital of Paris; Dr. Jamieson, from Edinburgh; and Dr. Radcliffe-Crocker, Mr. Malcolm Morris, and Dr. Pringle, representatives of the London School; besides many other dermatologists from all parts of Europe. Much interest was expressed in the case, but very few of us ventured to give any diagnosis. The peculiarities of the case consisted in that the patient had a very large patch on her neck and chest, which was tolerably abruptly margined and slightly scaly. The whole of her face was of a vivid red, and slightly but uniformly tumid. The swelling was sufficient to produce a little pitting, and to conceal her features. It did not, however, approach that of ordinary erysipelas.

It was difficult to get a very precise history of the onset of the disease. But there was no doubt that it had come on very rapidly, and equally little that for some time before the acute symptoms there had been present some skin disease on the face and chest. The conditions of the patch which had been

longest present, that on the chest, suggested to several of us a diagnosis of lupus erythematosus, and it appeared likely that the recent accession of acute symptoms was due to an attack of erysipelas spreading from these. The patient was very ill, and it seemed likely that she would die. The occurrence of erysipelas in connection with all forms of lupus is well known, and that which attacks lupus erythematosus is occasionally very rapid in its spread, productive of great exhaustion, and followed by death. Of this I have seen several examples.

*Ichthyosis in Streaks.*

Amongst the more interesting cases which I saw in Professor Kaposi's wards in the General Hospital was a very good example of that form of Ichthyosis which is arranged in streaks, and of which I have given figures in ARCHIVES, Vol. III., Plates XLV. and XLVI. Most of the examples of this disease which I have myself seen, and they have been a very considerable number, have shown a distinct tendency to deviations from bilateral symmetry, and in many cases the conditions have been definitely restricted to one side (see Plate XLVI.) The more severe the condition, however, and the more extensive the changes, the greater the probability that both sides will be affected, and that there will be some approach to symmetry. The cases, however, always very definitely differ from the common type of xeroderma and ichthyosis in that the changes are not diffuse, and that some parts of the skin are entirely exempt and perfectly soft and normal. The common form of ichthyosis affects in greater or less degree the whole of the skin, and is, so far as my knowledge goes, always symmetrical. It is also usually a "family disease"; that is, if there be several children in the same family, more than one will be found to suffer from it. The form now under consideration, however, is, I believe, never seen with any family history whatever, but occurs as a sort of accidental arrest of the development of the skin, in a quite isolated manner to single children. The statements which I have just made will be easily apprehended by any of my readers

who will take the trouble to turn back to page 288 of Vol. III., near to which is Plate XLV., together with a tolerably full description. Plate XLVI., showing a much more slightly marked example of the same disease, will be found at the end of the same volume. Professor Kaposi's case offered the most severe example of this malady which I have ever seen. Its subject was a little girl of perhaps twelve years old. As far as I examined her the conditions appeared to be symmetrical, and they were very nearly, but not quite, universal. The arrangement in streaks was, however, very conspicuous, and there were some patches of skin which were quite healthy and soft. The parts which suffered most severely were the elbows and knees, the palms, ears, scalp, and arm-pits. These parts were roughened by the development of almost horny spines which were blackened by dirt. In particular the upper borders of her ears were crested over with growths of this kind a quarter or a third of an inch high. The horns, as far as I could judge, were in part due to papillary growth, and in part to sebaceous accumulations. The disease was so severe on the extremities as almost to disable the child from any use of hands or feet. There was no family history of tendency to skin disease. The conditions had of course been congenital, but had much increased since birth, and especially of late years.

*Erythema-Scirrhus of the Skin in association with Cancer of the Breast.*

Professor Kaposi had also under his care a very remarkable example of the rapid spread of erythematous cancer of the skin. The condition of "scirrhus en cuirasse," as it has been named, had developed over a large part of the trunk, and was rapidly increasing. It was in association, as usual, with cancer of the breast, and the statement was that the whole had been developed in the course of nine months. I may confess that this to me was almost incredible, and the women, on being pressed, admitted that she might have had the tumour in the breast for two years. She entirely denied, however, any longer duration. The erythematous infiltration of the skin was very superficial, and was attended simply by

redness with a slight degree of induration. Until touched by the finger the conditions might easily have been taken for a slightly-marked form of erysipelas, the spreading edge presenting much more vivid congestion than the rest of the patch. The patient, a woman of fifty-three, was of course confined to her bed; but she stated that she did not suffer much pain. The parts in which the disease was most advanced had undergone some contraction. I have never seen a case so extensively advanced with so short a history.

Scirrhus infiltration of the skin presents not infrequently very remarkable features. It has occasionally close resemblance, and even some analogies with lupus erythematosus. I have seen cases in which the early stage was nothing more than erythema, sometimes dusky and purple, at other times bright, and without the slightest trace of induration. It may be conjectured that in these cases, as in lupus erythematosus, the cell infiltration occurs chiefly in the perivascular spaces. The conditions are often so superficial and so purely erythematous, that they are difficult of recognition. Satellite patches of erythema are often, indeed very usually, seen near to the borders of the chief area. These are exactly similar to what we see so commonly in lupus erythematosus, in infective eczema and in erysipelas, and they are no doubt to be explained in these dissimilar diseases in the same manner—that is, by the spreading of infective cell-material in lymphatic or perivascular spaces. Most of the more typical examples of scirrhus en cuirasse—that is, those which fix the chest in a sort of board-like induration, spread, I think, very slowly, the disease occupying several years. The erythematous form of scirrhus may, however, spread much more rapidly, and of this Kaposi's patient, whom I have described above, affords a good example. I have quite recently been asked by a distinguished surgical friend to see, with him, a lady on whom he had operated about a year ago. The object of our consultation was to determine whether certain large red patches which had appeared on the mammary region were eczema or cancer. The patches in question had their bases at the line of cicatrix, and were advancing with abruptly-defined margins into the healthy

skin. Near to their margins were several little satellite blotches of erythema. It could scarcely be said that the patches had any induration, and the congested vessels could be emptied quite easily by pressure. I could, however, feel no doubt whatever that they were really examples of cancer-erythema. This opinion was partly based upon their resemblance to conditions which I had seen in other cases, and partly upon the presence, when the finger was lightly passed over the patch, of a slight degree of perceptible induration. I was interested by the information that at the time of the operation the skin was a good deal congested. Although the patient was elderly (upwards of sixty), the original growth had been exceedingly rapid in its progress. The tumour at the time of its removal was large and adherent to the skin, but its presence had been recognised by the patient only a few months.

### *Cases of Lupus-Elephantiasis.*

Under the name of "Lupus tumidus" there were two magnificent models exhibited in the Congress Museum. In each instance the entire lower extremity was depicted. One of them was from the clinic of Dr. Hans Hebra, and the other from that of Dr. Lang. In each instance the entire extremity was involved in lupoid scar, with little patches of lupoid granulation structure scattered here and there. In each there was very considerable solid œdema, which especially affected the foot and ankle. These latter were very much enlarged, of elephantoid aspect, and covered with huge bossy masses of papillary growth.

These cases, of which I have seen several in English practice, although none perhaps quite so extensive, are of much interest as illustrating on one hand the tendencies of lupus, and on the other the way in which elephantoid hypertrophy is produced. They are usually cases in which lupus begins on the foot itself, and, in conformity with what is generally observed when lupus attacks the terminal part of an extremity, the disease is attended by much inflammatory œdema. The lupus, as lupus, spreads by its serpiginous

edge upwards, and may involve, as in the above case, the surface of the entire extremity. Meanwhile the solid œdema of the foot is slowly productive of its own series of nutritional changes. These consist not in anything of a lupus character, but in overgrowth. The persistent œdema and hypertrophy very usually receive repeated assistance from recurrent attacks of erysipelas, and a condition in no way distinguishable from elephantiasis is the final result. The epithet "tumidus," although well descriptive of a part of the process, by no means includes the whole, and the name Lupus-Elephantiasis is, I think, the only one really applicable. It is to be noted that in a few cases lupus of the extremities (of the hand rather than of the foot) results in exfoliation of bones and atrophy instead of overgrowth. To these cases, much more rare than elephantiasis, the term "lupus mutilans" is applicable.

*Furuncular Diseases in Nuremberg.*

Diseases of the furunculoid class are apparently very common at Nuremberg. No fewer than forty cases a year are recorded in the Nuremberg statistics at a hospital which records, in the same period, only ten cases of psoriasis. In addition to these about four cases of carbuncle are recorded annually, the subjects of which were all men. Under the name of furuncle, women bear a proportion of about one-third. During the year 1886 no fewer than 60 cases were admitted, 32 being men, 28 women. In addition to these we have to count a certain number, say 10 a year, treated in the same hospital in a special department for skin diseases. A very large number of cases also appear in the class of "phlegmonous inflammations," a family which includes phlegmon, erysipelas, lymphangitis, abscesses, and panaritium.

[I have pleasure in referring my readers to a very interesting account of the Vienna Congress of Dermatology from the pen of Dr. Jamieson, of Edinburgh, in the current number of the *Edinburgh Medical Journal*. In some instances Dr. Jamieson and myself have dealt with the same facts and cases.]

## RARE FORMS OF ABDOMINAL TUMOUR.

I HAVE recently had under observation two cases which seem worthy of being placed on record as examples of very rare forms of abdominal tumour. In neither, as yet, has there been an opportunity for ascertaining the exact nature of the growth. They are not in any sense parallel cases, excepting in their being examples of what is unusual. In one the growth has been present half the patient's life time, and is clearly innocent, whilst in the other the presumption is strongly in favour of malignancy.

CASE I.—*An enormous Tumour of uncertain nature, possibly Cystic, and developed in the abdominal wall.*

An old woman whom I saw some months ago in the White-chapel Infirmary was (and still is) the subject of a very peculiar form of tumour. It is an enormous rounded mass, and might have been taken at first sight for an umbilical hernia. It did not, however, begin at the umbilicus, but lay to its left side. The navel itself, which is shown in a rough drawing which Mr. Swainson did for me, is quite uninvolved, and a little displaced to the opposite side. The tumour could be lifted about from side to side quite easily, and might have been supposed to be developed in the abdominal wall had it not been that it appeared to receive a slight, but very decided, expansile impulse when the patient coughed. Against the idea of its being of a hernial nature, however, were the facts that it was not, and never had been, the least reducible, and that it was absolutely dull on percussion on all parts. On its front, and to the left, it had the consistence of a soft solid, though it might easily have been thought to fluctuate. To the right, however, it was very much softer, and as far as the

evidence of the fingers went it was impossible not to believe that it contained fluid in large, thin-walled cysts. An exploratory puncture had been made before I saw the case, but in the middle of the tumour, and not where, as it appeared to me, the sense of fluctuation was most distinct. The patient stated that the tumour had been gradually growing during half her life, and she was now between seventy and eighty. It had never been considered to be a hernia, and she had never worn a truss. A surgeon had once suggested its removal, but another had warned her strongly against it. It had never given her much pain or inconvenience, excepting from its size.

I publish the notes of this case thinking that possibly some of my readers may like to examine the patient. I dare not venture any positive diagnosis. It was through the politeness of Dr. Larder, the resident medical officer of the institution, that I saw the patient. She is still an inmate of the workhouse, and I have no doubt that Dr. Larder would be glad to allow any surgeon—interested in the attempt to make a diagnosis of a most unusual case—to examine it.

CASE II.—*A Multilocular Cystic Tumour in connection with the liver filling the abdomen—Repeated paracentesis—A Secondary Growth in the Neck.*

The condition of Mr. G—— may be briefly described as resembling that of a case of large ovarian tumour. He was, however, a man. The tumour filled his abdomen to about the size of the last month of pregnancy. It fluctuated freely, but the wave was not transmitted easily from side to side, thus suggesting a multilocular cyst. The surface of the abdomen was also quite different from that of ascites, the bulging being not evenly rounded, greater on the right side than the left, and the sides not being filled out in proportion to the prominence of the centre. Thus, from the first glance of the abdomen, I felt confident that we had to deal with an encysted tumour. It may be remarked that the parieties of the abdomen were thin and examination easy. The history given was that the enlargement had taken place gradually during two and a half years, and wholly without pain. The first bulging had been

noticed a little to the right and above the umbilicus. The patient was a man about thirty-seven, married, and the father of three children. He was a German by birth, but had lived many years in T——. He had not suffered from any special illnesses, but during the growth of the tumour, and especially of late, he had emaciated and become very sallow. His aspect was that of a patient suffering from malignant disease, and, although not distinctly jaundiced, he looked as if he had been so. As regards this point, it was difficult to know how much allowance to make for climate. He had but just landed when I saw him, having come over to England expressly for advice. He told me that he had been three times tapped. The first occasion was in October, 1889, when about a pint of fluid was removed. On the second occasion little or no fluid was obtained; but on the last, nearly two pints. This last was only just before he sailed, and, although it did not very materially diminish the size of the tumour, he thought that it gave him some relief. He had been liable to sickness before it was done, and this had entirely ceased afterwards. He had borne his voyage well, and was the better for it. Quite recently, that is within the last few months, a tumour had been detected on the left side of his neck. It was just above the clavicle and behind the sterno-cleido-mastoid. It was about the size of a child's fist, had apparently very thin walls, and fluctuated freely. The discovery of this second tumour seemed at first sight almost conclusive as to the infective and malignant character of the one in the abdomen.

The above notes were taken after an examination in my own room. I recommended our patient to become an inmate of a surgical home, and to let me tap him and make a further examination. The previous tapplings had been to the right of the navel. I punctured him in the middle line, and probably entered the cyst, which had not been tapped before. We drew off about a pint and a half of an opaque, blood-stained fluid. It had a greenish tinge, and looked as if it contained bile. The tapping had the result of producing a depression in one part of the tumour, but it did not take away more than a tenth part of the mass, and it rendered it very evident, what we had supposed from the first, that the mass was composed

of many cysts. Some further details may be given as to the examination of the abdomen. The liver dulness appeared to be continuous with the tumour, but there was not the slightest lifting of the ribs or fulness in the region of the liver itself. The percussion note in the flanks varied from time to time. On one occasion it was distinctly tympanitic on the left side over a considerable area, but on several others it was quite dull. Although the tumour passed well down to the pubes, I thought I could find distinct evidence of an edge under which the finger could be pressed. The right flank was always dull. The resonance was quite clear over the region of the stomach. There had never, from first to last, been any urinary symptoms.

Examination of the fluid which had been removed revealed a great number of little shreddy masses of yellowish-white appearance, which easily settled down to the bottom. We used a powerful aspirator, and I had moved the end of the trocar about rather forcibly in the endeavour to enter other cysts. On the supposition that the tumour consisted in part of solid growth, these shreddy fragments might very possibly have been detached by the procedure described, which was at the time attended by distinct bleeding. The microscope did not detect any definite structure in the shreddy substance which has been described. In the fluid there were great numbers of very large compound granular cells. These varied much in size, were very conspicuous, and some of them very large indeed. The opinion which I formed from the above facts was that the tumour was developed from the liver, that it was a cystic formation, and probably of malignant nature. As the man had travelled a great distance for advice, and as I did not see my way to recommend any operative procedure, I suggested to him that, before returning, he should have the advantage of a consultation. My friend Dr. Barlow accordingly saw him with me, and as he agreed with me that it was not a case for operation, the patient returned to his home.

[I shall be much obliged to any of my readers who can inform me as to the sequel of this case.]

## ON KELOID.

A DESCRIPTION is a very different thing from a definition. The one concerns itself with the external features of the object described, and is content to facilitate recognition. The other must go much deeper and must endeavour to seize those characters which are essential, but which, it is very possible, may not be attended by any conspicuous outward signs. It would be easy to describe Keloid as consisting of smooth, glossy growths, almost invariably developed in scars in the skin, and presenting the peculiar feature of having spurs running out from the edges of the patch. Such a description, more especially if helped by a pictorial illustration of a typical example, would enable any one easily to recognise all the well characterised cases. If, however, we attempt a definition of keloid we must take a much wider basis and must arrange for the inclusion of a number of forms which are distinctly not well characterised. Our definition might probably be,—An auto-infective fibroid hypertrophy of scar tissue. Under this definition we should have to describe several other forms very different in external appearances from the spurred and glossy growths which Alibert first recognised, and of which the peculiarities are now so widely known. The essential point concerning keloid is that scar tissue,—or tissue on its way to the formation of scar,—may take on a peculiar form of hypertrophy, which may prove very persistent and which, not restricting itself to the scar in which it originated, may grow into the adjacent skin. That the keloid growth possesses infective qualities is further proved by its occasionally producing new growths at distant parts.

It follows from these statements that inasmuch as scars differ greatly in their qualities and mode of origin so we must expect the keloid which results from them to vary.

So long ago as the year 1864 I wrote\* : "Keloid appears to me to be essentially a disease of cicatrix tissue, and I much suspect that it never originates in normal skin." From that time onwards I have never believed that there is such a thing as "spontaneous keloid." Now that, by general usage, the term keloid is restricted to the scar form—the Keloid of Alibert—and is never applied to morphœa, we may, I think, suitably discard the terms "true" and "false" as having no signification, and with them also, so far as my own belief goes, the term "spontaneous." All keloid is true and all is cicatricial. In the case to which my remarks referred the disease was believed to have been spontaneous, but on careful examination and inquiry I had found numerous scars of small-pox, and obtained a history of a scald. In 1880 I was nominally a member of a committee of the Clinical Society which made a report on Keloid.† My colleagues, Sir Dyce Duckworth, Dr. Living, Dr. Radcliffe Crocker, and Dr. Goodhart, should have all the credit of this report, for I did no work in respect to it. At that time my own opinions were fully formed and had been repeatedly expressed. I had drawn attention to the possibility that such small scars as those of boils, acne, and small-pox might become the sites of keloid, and to the fallacy thus presented in that the patient might easily deny the previous existence of any scar. I had also expressed the opinion that all keloid growths exist under a law of limited duration, and that they all tend sooner or later to soften and disappear. In April, 1885, I published a Lecture ‡ "On the conditions which precede Keloid, and on some rare forms of that disease," in which the above opinions were again discussed. If

\* "London Hospital Reports," vol. i., p. 92. In 1887 I find that I wrote yet more strongly : "When I express the opinion that it never begins excepting in scar-tissue, that it is in fact a disease of cicatrix, I give you the result of careful clinical observation, and I am aware that I differ somewhat from previous writers." See the Fourth Volume of the same Reports.

† This report is embodied in the chapter on Keloid in Dr. Radcliffe Crocker's excellent work on "Diseases of the Skin," p. 482.

‡ See *The Medical Press and Circular*.

I now venture to return to the subject, it is because the subject is of great pathological as well as of clinical interest, and may, I think, be made to illustrate some very important laws.

Defining Keloid to be a fibroid hypertrophy of scar-tissue which is aggressive and in a feebler sense infective, the following propositions may, I think, be ventured respecting it:—

1. Although it is denied that keloid ever begins in uninjured skin, yet it is not to be doubted that it may originate in very small scars and spread far beyond their limits.

2. The cases which begin in small and scarcely recognised scars, although usually attended by very slow growth, show remarkable persistence.

3. There is a natural law of decline and final disappearance which attaches to all keloid, although the disease may in exceptional cases persist for twenty or thirty years.

4. It is remarkable that keloid growths, although infective in continuity, and thus serpiginous, show little or no power of reproducing themselves in distant parts unless scar tissues be there present.

5. If, however, old scars be present on distant parts, then the development of keloid in a new one may become the means of infecting some of the old ones and causing them to produce similar growths.

6. The important law just stated makes it probable that in all cases of keloid, infective germinal matter is shed into the blood, but that it cannot in healthy skin find a suitable home for development. The law is well illustrated by the case of a negro, which I published, in the London Hospital Reports, in whom many scars, left by cupping, which were quite healthy until keloid was produced by a scald, took on the disease afterwards; and also by a parallel case in which the scars of small-pox were affected in the same way as the consequence of infection from keloid in the scar of a scald.

7. Although keloid is possibly a near ally of sarcoma, and although some of its modes of growth resemble those of a malignant disease, yet it never takes on malignant action,\*

\* I am not aware of a single case on record in which cancer had developed in a keloid patch. Cancer of scars, on the contrary, is well known. I have seen

*i.e.*, never ulcerates or fungates, or causes gland infection. When once keloid has softened and undergone resolution, it never returns.

8. Those cases in which the keloid forms immediately after the injury, and develops rapidly, are very hopeful as regards speedy involution. So also are those which occur in young persons, and those which are unusually extensive.

9. However long a keloid patch may have existed, there is still hope that it may go away.

I will now proceed to narrate some recent facts bearing upon the statements which I have just made. Others will be found in the Lectures to which I have referred, and also in papers already published in my ARCHIVES (see Vol. I., pp. 197, 335).

*Large Keloid Growths in Vaccination Scars of twenty years' duration.—Satellites and Secondary Growths on Distant Parts.*

Miss H——'s case is of much interest because it seems probable that the original keloid growths have proved infective. She was vaccinated for the first time at the age of nine, and the scars left at once took on keloid induration. She is now thirty years of age. From the vaccination scars long streaks with spurs have extended upwards and downwards. Other growths have also formed, two on the left shoulder within six inches of those on the arm, one on the left buttock and one small one in the scar of a burn in front of the right wrist. There is no proof that scars existed on the shoulder or buttock where the growths have occurred. She has also very small spots on the right shoulder and right hip. She is quite unable to assign the dates at which these secondary growths have formed. The burn on the wrist was only three years ago.

It appears that the vaccination keloids are softening and wasting, but they have of late become painful. She describes the pain as being occasional but very severe when it comes.

several cases in which it was exceedingly difficult to decide whether the disease was sarcoma, scirrhus or keloid, but they were always such as presented difficulties from the very first. I have never, I repeat, seen a structure which had been for a considerable period characteristically keloid pass into cancer.

She lays much more stress on it than on the itching. The newly-formed keloids are not either painful or irritable.

It is not quite certain that in this case the keloid lumps which formed in the vaccination scars have been the parents of all the others.\* Whether the secondary growths have developed in uninjured skin or in scars which had been overlooked it is impossible to say. The keloid growth on the left buttock is a very well characterised patch a quarter of an inch thick, and as big as a florin. It is red and glossy.

It is of interest to note that the secondary growths appear to have developed rather separately and gradually, and at considerable periods after the original one. This is different from what we observe in multiple lupus, in which all the secondary formations usually occur as a crop immediately after the beginning of the parent one. That there is a considerable constitutional tendency on the part of the patient may perhaps be inferred from the facts that both the vaccination scars have suffered, and that the growths have extended to considerable distances into the sound skin above and below. It would appear that these original growths have now ceased to extend and are, indeed, undergoing slow involution. Miss H—— brings with her a pen and ink sketch taken by Mr. C—— seven years ago, in which they appear at least as large as now. In several parts they have recently thinned away. Miss H—— knows of no history of malignant disease or any kind of tumours in her family.

*Subcutaneous Keloid Masses after division of plantar fascia.*

In the case of a young lady who was the subject of pes cavus in connection with some form of infantile paraplegia, the plantar fascia had been divided for its relief. I saw her about ten months after the operation, and in each sole at the site of the operation there was then an ill-defined lump of considerable size adherent to the skin, evidently a kind of

\* There is a possibility that the burn on the wrist (three years ago) may have proved an independent source of new keloid infection. This supposition would explain the anomalous features in the case. The dates cannot be given with accuracy.

subcutaneous keloid. The surgeon who had performed the operation had subsequently expressed a wish to excise the keloid indurations, but this had been wisely declined by the patient.

*Cicatricial Keloid in three generations (father, daughter, and granddaughter).*

An instance of the inheritance of tendency to cicatricial keloid came under my notice in the case of Mrs. M——. This lady had two large keloid patches of the most marked character in the middle of her chest between the breasts. She told me that one of them occupied the scar of an operation for the excision of a patch as large as a thumb-nail twenty-five years ago. The first growth had probably originated in the scar of a pustule. Immediately after the operation the scar took on the same condition, and soon advanced to five times the size of the first. For this she then consulted the late Dr. Tilbury Fox, who advised that nothing should be done further. Mrs. M—— told me that her father had suffered from the same disease in the same region, and that he had furnished the original for one of Sir Erasmus Wilson's drawings. His patch was, she said, much larger than her own. She added, "and one of my daughters has a patch also." I asked if I could see this daughter, and finding that she was sitting outside in their carriage, had her at once fetched in. She had a small keloid, recently grown, in the scar of a cut by a knife, just above her wrist.

*White Keloid, with peculiar features, in the Scars of Boils (Sub-epidermic Keloid).*

Miss R——, from Leeds, for whom ten years ago I excised a sort of sub-epidermic keloid patch from the left subclavicular region, comes to me again to-day (May 22, 1871). The scar, which is just midway between the sterno-clavicular joint and the nipple, is white and quite supple. There is not the slightest tendency to the return of the disease, nor has there been since the operation. All the needle punctures, however, are conspicuously marked with little discs of white scar. They are just a little raised, and can be felt by the finger; but there

is nothing in them approaching to a definite keloid condition. She still has on the shoulder, about half an inch below the tip of the acromion, a little white nodule of sub-epidermic keloid. It is about the size of a horse-bean. The epidermis over it appears to be almost healthy, although perhaps a little too smooth. It does not approach the glossiness of ordinary keloid: its margins are ill-defined, and it has nothing comparable to a spur. She tells me it was just its present size ten years ago. Both this and the one on her chest were developed in the scars of little boils. Both have been throughout quite white. She says that this little patch on the shoulder smarts, but does not itch, and she thinks it makes her shoulder ache. She tells me that in the original attack of boils, or impetigo, she had a number which left for a time little scars, but only these two finally took on the nature of keloid.

*Two large patches of Keloid with somewhat peculiar features.*

Dr. Foote, of Rotherham, sent to me in 1886 a lady of 39, in whom the history of scars was only indefinite. Sixteen years before I saw her she went through rheumatic fever with inflammation of the chest, and some time afterwards found a patch of keloid forming on a part where she had probably been blistered. She did not, however, take much notice of it for three or four years. When she came to me she had a patch over the middle of the sternum, oval, glossy, seamy, and very hard. There was another patch, seven inches long and three in width, under one arm. This latter was a quarter of an inch thick everywhere, and of a dusky-brown tint. It was not nearly so hard as the other was, indeed somewhat cedematous and slightly pendulous. Both patches were believed to be still growing. They were prone to itch and burn intolerably. Mrs. W—— was stout and in good health.

*On the relation of Lupus to Keloid of Scars.*

Common cicatricial keloid does occasionally follow the cure of lupus, but it is very rarely seen. The subjects of lupus do

not appear to be prone to organise scar tissue of the dense and hard character which constitutes keloid. Their scars do not easily become quite sound, and often present more or less of chronic inflammatory induration, but they are still far from resembling typical keloid. The latter occurs, I think, only where the healing has been completed rapidly, and is probably an indication of sound health so far as scrofulous tendencies are concerned. It belongs rather to proclivity to cancer than to scrofula.

In a few cases, very few, I have seen keloid in the scar of cured lupus. It has always been after unusually complete cure, and I think that the method by scraping is more likely to be followed by it than any other. The following are almost the only instances of the occurrence of which I have preserved notes.

*Single small patch of Lupus in middle of cheek—Keloid after scraping.*

Miss S——, *æt.* 23, was under my care in 1881 for a single small patch of lupus in the middle of one cheek. I scraped the patch. The cure was complete, but a little button of keloid formed in the scar.

*On Lupus-Keloid.*

Cases in which from the beginning a sort of lupus-process tends to the production of a keloid condition must be separated from those, such as the above, in which keloid follows the operative treatment of common lupus. Of this conjunction the two following cases appear to be examples.

*Curious case of Lupus-Keloid in the chin of a girl.*

A girl, *æt.* 15 (but looking like twenty), was under my care in March, 1884, and subsequently, for a very curious patch of lupus on the chin. It was about as big as a sixpence, and had very hard edges. It had no scab, being cicatrised and depressed in the middle. It was spreading at its edges. Its elevated edge was remarkably firm, and not very vascular, but in some parts spots of not very characteristic appearance

of apple-jelly-growth existed. It had been present nearly a year. Regarding it as lupus, I cauterised it freely with the acid nitrate of mercury. A month later it had quite healed, but the scar was still in a quasi-keloid condition. I saw her again three years later. The disease had not spread, and might be regarded as almost cured; but its edge was still elevated and bossy, like rodent on a very small scale.

It will be seen that it differed from common cicatricial keloid in having a depressed centre, and in the entire absence of spurs. Had it been in a senile person, I should have regarded it as an early stage of rodent.

*Eczema-Lupus, partly Keloid.*

A lady aged 62, in good health. She has a long patch crossing the anterior border of her left axilla. It is glossy, and a little indurated; *very red*. Abruptly margined, and the skin around it perfectly healthy. It is said to have been there five or six years, and it extends very slowly. It has no satellites. It is usually not in the least troublesome, but sometimes it inflames and becomes, from her description, eczematous. It is either eczema-lupus, or a minor form of keloid. There is no history of preceding scar, but it is just where her dress presses. It does not appear to be connected with the axillary hairs.

*Case illustrating an Eranescent form of Keloid, and also its hereditary transmission.*

There is a condition of keloid which is essentially transitory and of which, on that account, but little notice has hitherto been taken. In order, however, to make the pathological picture complete, it is essential to recognise it. Many recent scars are threatened with keloid induration during a few months after the first healing of the wound. At the end of six months or a year the tendency to growth has quite ceased and the cicatrix has softened down to at least level with the surrounding skin. These cases must, I think, be counted as the initial stage of true keloid, and it is to be understood that it is merely a question of intensity in the constitutional

tendency whether they develop into the more extreme and characteristic forms or not. Vaccination scars often for a time show this condition of things.

I have just had under my observation a case which illustrates the above statements, and, further, the hereditary transmission of tendency to keloid. A lady who had a keloid nodule in the lobule of her ear, which had been several times treated by excision and with invariable recurrence, bore an infant who was in due time vaccinated. During the year which followed vaccination and after the sores were soundly healed there was a distinct tendency to keloid growth in them. They even presented conditions which threatened the development of spurs. Towards the end of the year these formations melted away, and at present the scar is level with the skin, although still harder than natural.

#### *On Prurigo-Keloid.*

Having shown that keloid may attack scars which are in themselves exceedingly small—such, for instance, as those left by boils, acne, or blisters—I have next to make the proposition that certain conditions, in which scratching is the principal element, may be attended by keloid formations of a very peculiar nature. It is well known that pruriginous affections, in which habitual scratching has been practised, are apt to be followed by scars. Thus the skin may in some of these cases become marbled over with little white cicatrices. I have described this condition in detail in connection with the disease which I have ventured to name summer-prurigo. The step which I now wish to take is that of recognising that these little scars—the results in some cases almost solely of the use of the patient's nails—may become affected by keloid growth. When such is the case the patient may be mottled, over large tracts of skin, with little keloid nodules. The keloid in such cases presents peculiar features, and rarely, I think, shows much tendency to grow. I am speaking from the observation of but very few cases. As yet it has never happened to me to witness the formation of spurs or of any material invasion of the healthy skin. The little buttons are

almost always conical, or at most bee-hive shaped, and they seldom become either glossy or red, yet that they are of the nature of keloid according to the definition which has been attempted above, that is, fibrous indurations in scar tissue, I have no doubt. Although I have seen several other less well marked examples of this condition, I have in memory only three which can be regarded as typical and well characterised. Of these the first was brought to my notice by Dr. I. Mennell Williams, late of York, in the person of a lady who had for long been under his care on account of an obscure lichenoid eruption. This eruption had been most severely scratched, with the result that a large crop of keloid nodules had been developed. These were especially abundant on the arms and shoulders. It is many years since I saw this patient, but I well remember the very peculiar features of the case, which were at that time quite new to me. My second and third cases came under my notice almost together, and within the last year.

One of these I record in detail below, and the other was brought under my observation by Mr. Morrall Baker. The conditions displayed by Mr. Baker's patient are well illustrated by a model, photograph, and coloured drawing, which have been preserved in the collection of the Royal College of Surgeons. Mr. Baker's patient was a woman of about thirty, and her condition had claimed the interest of all who had seen her. I believe I may add that none had ventured to give to her eruption any special name. The eruption consisted in little dome-shaped indurations, varying from the size of a pea to that of the end of a forefinger, and scattered over the chest, arms, legs, &c. Many of them on their summits bore evidence of scratching, and all of them were at times intensely pruriginous.

*A Pruriginous state of Skin attended by Vesications and Abortive Pustules, and resulting in the formation of scattered Keloid Nodules of Conical form—Duration seven years.*

The case of Mrs. W— offers, I think, in some respects, a parallel to the important one recorded by Mr. Morrall Baker.

It is complicated by a tendency to other forms of skin disease, but in the main feature, the production of little conical indurations in the skin, the two are alike. In both cases the indurations occur chiefly on the backs of the forearms, arms and hands, and on the fronts of the legs. They are symmetrical. Mrs. W——, wife of a clergyman, is now 53 years of age. She is thin and pale, but not specially out of health. All her life she has had an irritable skin, having suffered, as she thinks, much more than others from fleas, mosquitos, and the like. She was one who “was always sure to get a flea if there was one about.” They used to produce urticaria-like wheals, but she does not think she was ever the subject of spontaneous nettle-rash. She could never wear woollen next the skin. Notwithstanding this susceptibility Mrs. W—— enjoyed, she tells me, a clear complexion, and entire freedom from persisting skin disease until about seven years ago. She then became liable to her present affection, which has lasted, in spite of treatment, ever since. Six years ago she was for a considerable time under the care of Mr. Windham Cottle, and subsequently, having been told that her affection depended on gout, she consulted Sir Alfred Garrod. Since then she has tried very various remedies, but without effect. When her affection commenced she was living in England, but she had previously spent many years in India. In 1866 she had suffered an attack of jaundice, but she does not remember that it was productive of any increase in the irritability of her skin. The condition for which she consulted me began, as stated, seven years ago, and as far as she can recollect its commencement was a little irritable spot on one arm, which was soon followed by a similar one on the other. She had no idea that she had been bitten and did not recognise any special cause. After this spots came over all her limbs. The irritation was intolerable, and she spontaneously described the sensation “as if there were a little seed in the skin which I must dig out with the nail.” The final result had been that her arms and legs became covered with little conical indurations, all of them presenting abraded tops. Some of them are as large as the tip of the little finger. There are also some abrasions without induration, and the skin generally has

assumed a dry condition with, in places, a tendency to diffuse eczema. The skin of her face generally is dry and so is that of the backs of her hands and fingers, with many little erythematous spots and a slight tendency to crack. Her face, as well as her limbs, is irritable, and has been much scratched and rubbed. She said that in some cases little watery blisters would occur as the result of rubbing on the limbs but that they soon broke and were followed by the deep-seated indurations which have been above described.

*A case of Prurigo-Keloid recorded by Dr. Hardaway, U.S.A.*

I have just found in the "American Archives of Dermatology" for 1879, a case recorded which, had I seen it, I should probably have claimed as belonging to the group of prurigo-keloid. The patient was brought before a medical meeting by Dr. Hardaway, and her case excited great interest. No name was given to the malady. As in my own and in Mr. Baker's cases, the patient was a woman. She was fifty-one years of age, and had suffered for twenty years. The prurigo was intense. The little nodules occurred chiefly on the extremities. In strong confirmation of the diagnosis of keloid, one growth (excised for microscopic purposes) recurred in the scar of the wound.

*(To be concluded.)*

## SYPHILIS.

No. XLII.—*Lupoid destruction of Alæ Nasi, with loss of Septum—Difficulty in diagnosis between Syphilis and Common Lupus.*

April, 1892.—Mrs. B——'s case was of importance on account of the difficulty of diagnosis between common lupus and the syphilitic form. Her nasal septum was extensively destroyed, and the tip and alæ in part removed by ulceration, and in part concealed by being doubled into the nostrils. One ala, a loose flap, was turned completely into the left nostril, and might be drawn out and put into place. This condition is not uncommon in syphilitic ulceration, but unknown in lupus vulgaris. The character of the existing ulceration on the upper lip and right ala was also exactly like that of syphilis, and not like that of lupus. By this I mean that it was an inflamed ulcerated surface with a pus-crust, but with little or no granulation growth.

There extended upon her cheeks large, ill-defined patches of dusky erythema. These might pertain either to syphilis or lupus vulgaris, but there was nothing in them characteristic of the latter.

Mrs. B—— was a widow, a schoolmistress, of about 50 years of age, and she had suffered from the lupoid disease several years. She was a very sensible person, and I ventured to ask her a direct question as to syphilis. She understood my inquiry, and told me in reply that she had no reason to think that she had ever suffered. She had no indications of taint that I could discover. A condition which favoured the diagnosis of common lupus was that of her gums. Those of her upper jaw were swollen and ulcerated

exactly like lupus, and not like syphilis. I treated the case by a liberal cauterisation with the acid nitrate of mercury, and gave iodide of potassium internally. The cauterisation was repeated, at intervals of ten days, two or three times, and with the result that in the course of six weeks the parts were soundly healed. The erythematous patches on the cheeks had also almost entirely disappeared.

I do not feel any doubt that this case, although corroborative history was entirely wanting, was really one of syphilis. We do not get such rapid and complete cures in common lupus. It will be seen also that the appearances described favoured strongly the diagnosis of syphilis. I record the case, and have described the appearances in some detail, because the differential diagnosis illustrated is one of very great importance. Scarcely a month passes without my seeing a case in which treatment has been conducted for years on the hypothesis of lupus, but which is cured at once on changing to that for syphilis.

No. XLIII.—*Some unexplained facts as to the influence of Sex in inherited Syphilis.*

There are some curious facts as regards the greater liability of the female sex to the later results of inherited taint. My attention was first drawn to them when writing on Iritic Keratitis in 1863, and although they have since then been confirmed not only by my own more recent experience, but by many other observers, no plausible explanation has been offered. The inequality referred to does not apparently obtain in the case of deaths from syphilis in infancy, nor as regards the prevalence of inherited taint in general, but only in reference to certain special affections.

The mortality at the Blackfriars Hospital for Skin Diseases is mainly caused by hereditary Syphilis. Its total is, however, very small. I find from our book of certificates of death, that, during a period of nearly twenty years, only seventy-one such certificates have been given. Of these, however, no fewer than forty-one were for Hereditary Syphilis, and several others are so worded as to leave the question doubtful. Of

the forty-one alluded to, twenty-two were boys and nineteen girls. Thus it would appear that the number of boys who die of infantile Syphilis at least equals that of girls.

In my work on "Inherited Syphilis as a Cause of Diseases of the Eye and Ear," I published a considerable number of cases of Iritis in infancy, and of Keratitis and of Deafness at later periods. On counting the whole of these up, it would appear to be the fact that the female sex presents a considerable excess of subjects of each of these forms of disease.

My facts stand as follows :—

Of Iritis in infancy, twenty-three cases in which the sex is specified, and of these eighteen were females and only five males.

Of Keratitis at various ages before and after puberty, but none in infancy, a total of one hundred and two cases, out of which sixty-four were females and only thirty-eight males.

Of Deafness at various ages (no infants), there are twenty-one cases, of which fifteen had Keratitis also, and are counted in the preceding statement. The subjects of the six cases not counted in the Keratitis series are all females, and of the fifteen so counted nine were females and six males. Thus we have totals of fifteen and six respectively.

My book also comprises, in addition to the cases included under the preceding statements, twenty others, in which for various ailments children or young persons, the subjects of inherited Syphilis, came under care. These were of various ages, but most of them beyond infancy. Of the twenty, thirteen were females and only seven males.

Mr. Hinton states that cases of deafness in connection with hereditary Syphilis constituted one-twentieth of his patients at Guy's Hospital. He gives no statistics as to sex, but states : "The great majority of cases that I have seen have been in females." \*

The most recent contribution to the statistics of the subject occurs in Mr. Brudenell Carter's Lecture, published in the *Lancet* for the 17th of December ult., page 1374. Mr. Carter gives as his experience of Interstitial Keratitis ninety-two cases, stating that he regards them all as resulting from

\* Page 461, Toynbee on "Diseases of the Ear."

inheritance of taint. Of these, sixty-one were females and only thirty-one males. As regards ulcers of cornea (not syphilitic), the proportions of the two sexes were equal.

No. XLIV.—*The complete success of the Abortive Treatment a source of dissatisfaction to patients.*

Patients in whom the abortive treatment has been successful not infrequently come to entertain a suspicion that, after all, they have never had the disease. Such was the case in the following instance. Mr. W. E. A. called on me with the express purpose of obtaining an opinion as to whether he had had the disease or not. His facts were as follows: He was exposed to risk (on a single occasion) on January 2nd. He noticed nothing until five weeks later, when there was some irritation which resulted in two little sores in the under surface of the prepuce, near the corona. These he showed to a medical relative two weeks later, who told him they were chancres, and advised him to see a specialist. This he did a week later, that is, two weeks from the appearance of the sores and seven from the date of contagion. Mr. Buxton Shillitoe pronounced them hard sores, and said that he feared that it was too late to prevent secondaries. At this time the two sores were large and quite distinct from each other. Mercury was at once prescribed—a grey powder pill three times a day. In eighteen days the sores were healed, and in five weeks from the beginning of treatment not a trace of either remained. The pills were continued, and for a time were taken four times a day. At one time there was slight ptyalism. From first to last no eruption on the skin and no trace of sore throat appeared, and when Mr. A. came to me after nine month's treatment, he was wholly free from symptoms, excepting some slight enlargement of inguinal glands. I, of course, told him that he had certainly had infecting chancres, and that he was indebted to the treatment for his escape from secondaries.

I publish the above case, not as an example of what is rare, but of what is very common. Those who practise the abortive treatment must look to encounter not infrequently

very hesitating gratitude on the part of their patients. The popular idea of syphilis is that it is necessarily attended by a loathsome eruption and great loss of health. When the chancres pass away and nothing whatever follows, the patient begins to suspect that there has been an error. He cannot believe that a few boxes of little pills have really prevented so much. He has saved his fees, his health, and very likely his reputation : but he is quite unable to realise his obligation, and as frequently becomes rather suspicious of a blunder than grateful for skill. This unfortunate result is of course especially likely to occur if the surgeon be one not engaged in special practice. I therefore strongly advise all who use this method to explain fully that it is designed to prevent all consequences, and that probably with the disappearance of the chancre there will be an apparent end of the matter. In future years the abortive treatment will also render the recognition of a syphilitic history, in cases of remote tertiary disease, a matter of much more difficulty than at present. We now, in taking a patient's history, rely much upon the previous occurrence of what we know as "complete syphilis," meaning by that expression a chancre followed by rash and sore throat. In the future very few cases will have this "complete" record. Almost all will tell us, "I once had a sore which Mr. — said was a chancre ; but it was soon well, and for my own part I do not believe it was one."

## RHEUMATISM AND GOUT.

### No. XXII. — *A case illustrating the distinctions between Rheumatism and Gout.*

The case of Mrs. N——, a very intelligent lady of 48, is of interest in reference to the distinctions between rheumatism and gout and also as to their coincident occurrence. It affords, too, a good example of the attacks of acute rheumatic gout which simulate rheumatic fever. Several of her relatives had suffered from true gout, and many from rheumatism. In particular her paternal grandfather had had many attacks of gout, and his son, her father, several of rheumatic fever. Mrs. N—— herself was a stout, rather florid lady, of not very vigorous health. She had been through life liable to quinsies, and she associated the quinsies in some way with her rheumatism, believing that a quinsy had often preceded a rheumatic attack. She had also in early life been very liable to “catch cold,” in the ordinary sense. Of late this had very much ceased, and she thought that proneness to rheumatism had taken its place. She never, even in early life, could digest malt liquor, and she had never taken wine regularly. Many years ago she had an attack which was called rheumatic fever, from which, after the usual duration, she recovered. Her recent attacks, of which she had had two, had been called rheumatic gout. One of these, two years ago, had confined her to bed six weeks unable to move hand or foot, and the last, six weeks ago, from which she had but just well recovered when I saw her, had kept her in bed ten days. I asked her how she distinguished these attacks from that of rheumatic fever, from which she had suffered in former years. She said that they had both begun definitely with gout. In each instance she described

as the first symptom a red glossy thumb, adding, "You know gout becomes red, but rheumatism doesn't." In these two latter attacks she had had much swelling about the carpus, and this had persisted for some time after the general rheumatism had ceased. All the smaller joints of her hands had also suffered during these attacks of generalised rheumatic gout, although the larger ones had also been implicated. There had also been great difficulty in perspiration, and she said that hot-air baths had been used with very little success in that direction. During the debility of her convalescence, however, the slightest thing made her perspire. From these attacks of acute rheumatic gout the recovery had been very complete; not a single joint had been stiffened or left permanently swollen. "When I get well, I get well," was her expression. The only exception to this statement when I saw her was a certain amount of thickening about the right carpus. There was no evidence of affection of the heart. Mrs. N——'s reason for consulting me was that she was suffering from rheumatic pains in various parts, and that her hand, as stated, was still swollen. She held that during the attack she could distinguish between gout and rheumatism in her different joints. She said that the pain was different. I asked which was the worst, and she said she thought the rheumatic. The gout joints, she said, felt sore, but they did not ache so terribly as the rheumatic ones. Her verdict on this point differs from that popularly received. It must be remembered, however, that she had not suffered from really severe gout. As regards the minor forms, I have no doubt that her expressions were quite correct. Sub-acute forms of gout, infinitely more common than the very severe, are not extremely painful, and they are attended, as she described it, by a sense of soreness rather than an aching.

I have to add to the above narrative, that Mrs. N—— did not consider herself very susceptible to weather, and did not usually know when the wind changed; she believed that she had formerly for some years prevented the joint pains by the habitual use of lime-juice at her meals. Having been told that it was debilitating, she had unfortunately left it off.

My theory in explanation of such a case as the above is perhaps a little complicated. In the first place, I should think there is little doubt that the patient has a double inheritance—first, of defective digestion and assimilation tending to the accumulation of urate of soda in the blood (= gout); next, an inherited susceptibility of the nervous system and tissues generally, involving a liability to general arthritis on exposure to the causes of cold-catching (= rheumatism). In explanation of the occurrence of acute generalised attacks, I invoke the theory of the infectiousness of the products of inflammation. The joint first inflamed probably furnished to the blood elements which infected other joints, and so on; the more that were infected the greater was the risk of further increase. This is the law which, so far as I can see, probably underlies almost all forms of inflammation, whether of the skin joints, mucous or serous tissues, which tend to become rapidly generalised. They are in a certain small degree analogous to the exanthemata, and the poisons which produce them, although not specific, and although accompaniments and products of the inflammatory process, are yet capable of self-multiplication in the system and enjoy only a limited duration of vital activity. Thus an attack of rheumatic fever, or one of gout, or of any like inflammation, tends to come to an end spontaneously with a certainty only slightly less than that which we note in smallpox or measles. In the case just recorded, the patient, it will be noted, asserted that her earliest symptom was a gouty inflammation of her thumb. From this a generalised arthritis, in part gouty and in part rheumatic, rapidly followed. That this generalised attack should be in the main rheumatic, or at any rate **not** definitely gouty, fits well with the theory which I have ventured to propound. An inflamed joint may easily be supposed capable of supplying to the blood elements capable of producing arthritis elsewhere, but it could scarcely increase to any material extent the quantity of urate of soda circulating in the blood, and it is upon the latter that the differences which we regard as distinctive between gout and rheumatism mainly depend. In all generalised attacks it must follow,

therefore, that the special phenomena of rheumatism will preponderate over those of gout. If gout be really severe and well characterised, it restricts itself to one, two, or, at most, a few joints, because its specific poison is not capable of indefinite increase. If the arthritis becomes generalised, or makes any approach to being universal, the gout peculiarities become merged and lost in those of rheumatism, for the rheumatic elements, as suggested, are capable, indeed are prone to, quite indefinite multiplication. Thus gouty proclivities, by starting a local arthritis, may become the parent of rheumatism.

No. XXIII. — *Severe tophaceous Gout—Enormous chalk-stones on hands—Minute tophi in the substance of the irides near their ciliary margins.*

A man named W——, an inmate of the Kensington Work-house, who was shown to me by Dr. Potter, the resident physician, offered a good example of almost uncomplicated gout. He had very large chalk accumulations in his hands, which quite crippled him. His age was 42, and he had been an ostler. His father, who was a brewer, had died of gout. He was, excepting his liability to attacks of gout, in good health, and he had never had rheumatism, in any definite form, apart from gout. The tophi on the backs of his hands were as large as a child's fist—the largest, I think, which I have ever seen. His feet were similarly affected, but none of his larger joints were stiffened. There were, however, exaggerated osseous lips on the condyles of his femurs. There were no tophi in his ears with the exception of one on the back. The eyes in this case presented a very noteworthy condition (portrait taken). They were exactly alike. Near the corneal margin of the iris were a number of little wedges of white about as big as pins' heads, but angular in outline. They were not seen in the upper part of the iris, where covered by the upper lid, and were very small and few in number at the lower border, where partly covered by the lower lid. They were largest exactly opposite the commissures of the lids. I have no doubt that they were urate of soda, and it

is interesting to note that exposure to light had probably had much to do with inducing their deposit. No inflammation of the eyes had ever occurred, and the deposits in question caused not the slightest inconvenience. They had been first observed by Dr. Potter, who drew my attention to them.

No. XXIV.—*Lumbago and Aural Pruritus with Seborrhœa in their association with Gout.*

V—— de B——, a German wine-grower, came under treatment on account of a modified form of lumbago. He was a tall, finely-developed man of nearly 50. He was accustomed to drink both claret and champagne, but told me, on my advising him to abstain totally from the latter, that he was well aware that it did not agree with him, but that in the course of business he was almost compelled to drink it. The peculiarity of his lumbago was that he thought that it was increased rather than made better by exercise, whereas lumbago, as a rule, is got rid of by active exertion. I am not sure that in this instance the patient was correct in his impression, or that he had really walked with sufficient energy. His lumbago, he said, was always worst in the evening, and although he chose to think that this was due to his having walked about in the day, it might easily be that the real cause was the champagne taken at dinner. His lumbago had not been severe, and he described it as “a slight, sleeping pain,” which always kept him in anxiety lest it should get worse. On only one occasion had he had anything which could be considered as definite gout, and then the attack, which consisted in pain and stiffness in the great toe, had but a very short duration. He had, however, often been threatened by pricking pains in the thumbs and other joints, and he had often seen uric acid in great quantities. Thus I think it may be assumed that he was unquestionably gouty. My interest in this case begins with the proof of the existence, in varying intensity at different times, of true dietetic gout. With this I wish to connect a symptom which has received

but little attention. I refer to the occurrence of a pruriginous condition of the external ear, associated with which was occasionally a definite seborrhœa and transitory deafness. I have met with this repeatedly, and feel sure that it is a symptom and result of latent gout. It is important to prove this, for if gout can cause seborrhœa of the ceruminous glands, it may be competent to the production of seborrhœic eczema, and other disturbances of the sebaceous glandular system. There is still much debate amongst dermatologists as to whether gout has anything to do with eczema. For my own part I have no hesitation in answering such a question in the affirmative. Although most cases of eczema are chiefly due to local causes in their origin, and all cases are undoubtedly due chiefly to local causes for their aggravation and persistence, yet I hold most firmly that constitutional influences take their share in the process. When the blood is gouty, the skin is irritable; in many persons a slight error in diet in the direction of gout will make the skin in certain parts itch intolerably. With this pruriginous condition there is very apt to be associated local activity in the sebaceous glands; or, if this be not present at first, it may be easily produced by the scratching which the pruritus induces.

To return to the subject of seborrhœa of the ear in its association with gout. The patient, whose case I have mentioned above, is only one among many who have complained of temporary attacks of deafness, and have said that these were usually associated with a moist, sticky discharge. Attending this discharge, and usually preceding it, was intense irritation deeply seated in the auditory canal. That the discharge is the ordinary secretion of the ceruminous glands its stickiness, colour, and smell all combine to prove. The discharge is always very much increased in quantity if the patient yields to the impulse to put his little finger into his ear. Our patient in the case narrated had suffered repeatedly from these conditions, and he was very clear in his testimony that the attacks always occurred when he knew from other symptoms—pains in his joints, the appearance of uric acid, &c.—that he was gouty. As his case presented no peculiarity in this respect, I may here leave it,

and may narrate another yet more definite in proof of my position.

A member of our own profession, and an accurate observer, has been good enough to supply me with the data of his own case. He inherits a tendency to gout, and has suffered repeatedly from slight attacks of pain in the great toes at night and in the thumb joints. He has also often seen uric acid in abundance, and is very susceptible to errors in diet. Although he lives by rule, he is obliged to live well, being one of the many who aver that they never feel up to their standard of tone unless they are on the verge of gout. To go to the edge of the precipice, and not to fall over, is his favourite problem. Now this gentleman has been troubled much and often by *seborrhœic otorrhœa*. His attacks always occur in conjunction with other symptoms of gout, and they are always remedied by increased care in diet, and the use of alkalies. The symptoms begin by intense itching deep in the external ear. It is, my friend asserts, impossible to avoid the application of the finger, and this soon causes the discharge of fluid wax. If the condition be neglected, and especially if the finger be used more vigorously than ordinarily, the ear may be made to throb, and an attack of general inflammation of the canal may be threatened. Attendant upon this condition, after it has lasted some time, there is usually heat, slight tenderness, and stiffness of the whole of the cartilage of the external ear.\*

In the case of my friend, deafness, sometimes to a very troublesome extent, often attends the *seborrhœa* condition. It does not appear to be wholly, or even chiefly, caused by the blocking of the canal by secretion, and it is persistent in greater or less extent in the attacks. I suspect that it is in connection with implication of the joints of the bones of the ear in the processes of rheumatic gout. In the case to which I am now referring, entire immunity from the liability to pruritus and *seborrhœa* has been repeatedly attained for a

\* I believe that Sir Dyce Duckworth has described the condition of stiffness and induration of the cartilage of the external ear in connection with gout, and I have little doubt that this state is the final result of neglected attacks such as those which I have described.

period of a year or so at a time. There is, however, invariably a recurrence unless the greatest possible care be exercised in reference to wine and fruit.

No. XXV.—*On the possible association of Herpes Zoster with Gout.*

It is a question of much interest whether the peripheral neuritis which produces shingles is ever itself of gouty origin. A considerable number of the severe cases of ophthalmic zoster certainly are met with in elderly persons of gouty proclivities. It is at the same time undoubted that many of them are in no such association.

An old gentleman of nearly 80 consulted me on account of the state of his arm, which was quite crippled as the result, he said, of an attack of shingles. His fingers were wasted and stiff, and his thumb was bent over towards the palm, and seemingly ankylosed at its carpal joint. It might be that these changes were in part the result of his having had the hand kept for some time in splints. It did not appear probable that he would ever regain the usefulness of his hand. The wrist itself was involved in the stiffening, but not the elbow. Mr. — was in very good health, with the exception—if it be an exception—that he was gouty. The account which he gave of his illness was that, whilst confined to bed with gout in the great toe, he was one night awakened with pain, about the left shoulder, of a severity which he had never before known. This pain persisted for a day or two, and was followed by an eruption which his medical attendants called zoster on the front of the upper arm. After this the whole of his hand was swollen and painful, and it was placed in splints, which were continued for some weeks. It did not appear that the eruption of herpes had been very severe or unusually extensive, and it had not left any scars. It was exceedingly difficult to say how much of the present muscular defect in the hand and forearm was due to herpetic neuritis and how much to rheumatic gout and stiffening from disuse. It appeared perfectly clear, however, that a sharp attack of herpes had occurred during one of gout.

No. XXVI.—*Severe Tophaceous Gout—Osteo-arthritis and much crippling of lower limbs.*

A man named S——, an inmate of the Kensington Infirmary, presented a remarkable example of the formation of tophi. His hands were quite disabled by them. At various parts on his fingers, knuckles, and backs of hands, were accumulations as large as walnuts, the yellowish-white tint of which showed through the thinned skin over them. His feet were also affected, and his ears were speckled over with spots of chalk. He walked very badly indeed, shuffling along as if both legs were stiff. I thought his knees must be ankylosed, but found that neither they nor his hips were fixed, although a good deal stiffened. This man held that he had gout only, and that he had never had rheumatism. That osteo-arthritis took a share in his case was, however, quite certain from the development of most conspicuous lips on the condyles of his femurs.

This man was, excepting his severe gout, in good health. He had been born in Suffolk, but had come to London at the age of 19, and, working in a foundry, had drank beer freely. His first attack of gout was at the age of 29. A brother of his had gout, but he did not know of any inheritance.

*Note on the State of the Teeth and Nails in Gouty Persons.*

I examined the teeth and nails both in this patient and in the subject of the preceding case. The teeth in both were in a most unpleasant condition from coating of soft tartar and accumulation of greenish mucus. They had, of course, been absolutely neglected, owing to the crippling of the patients' hands. In neither patient were the nails hard or polished. In the man Stiff, they were indeed somewhat fibrous, but he had suffered from acro-arthritis, and probably they had shared in inflammatory irritation. I mention these facts because I believe that there is some impression that the teeth of the gouty present peculiarities. I do not believe that they do, unless, indeed, we consider that not unfrequently they are more than usually sound, and that the saliva is especially prone to deposit tartar.\*

\* Hence, perhaps, the proverb : " You've got a good set of teeth ; mind you don't dig your grave with them."

As regards the nails in gout, it is certainly, I think, often seen among the better classes in England that those who are gouty have very good nails—thick, solid, transparent, and and brightly polished. I am quite aware that this type of nails is often also seen where there is no gout. They imply, as a rule, sound tissues.

No. XXVII.—*Recurring attacks of Congestion and severe pain in the Eyes in connection with Gout.*

I described many years ago, under the name of "Hot-eye," attacks of temporary congestion of the eyeball which occur in connection with gouty dyspepsia, and of which the principal symptom is a sense of heat. The attacks described often come on very quickly after an error in diet, and are usually very transitory, lasting, it may be, only a few hours. They are not attended by iritis, and those liable to them have them over and over again.

There is an allied condition of inflammation of the eyeball of much longer duration and greater severity which sometimes occurs to the gouty, and is curable by anti-arthritic remedies, which still falls short of iritis, and is never productive of adhesions. Of this, the case which I am about to narrate affords a good example. It also illustrates other points of much interest in reference to the results of inheritance of mixed tendencies to gout and rheumatism. Excepting by fruit-eating, it could not be held that the subject of it had done anything to augment or modify her inheritance. She had lived abstemiously, and had been for forty years an entire abstainer from alcoholic stimulants. Fruit, however, she had taken freely, and here perhaps was the chief error of her life. Neither gouty iritis nor attacks of hot-eye as a rule occur to young persons, and in the present instance the liability to attacks of ocular congestion did not commence till the age of fifty-five. In making this statement I put aside for the present the well-marked group of cases in which insidious iritis with affection of the vitreous occurs in young subjects who inherit.

Mrs. F——, 65, widow of Dr. F——. Although born in

Scotland, Mrs. F—— assures me that all her relations for several generations have suffered from gout. Her grandfather and her mother, both, for long went on crutches crippled by rheumatic gout. Four of her children have suffered severely, and two have had their eyes inflamed. She herself has had one acute attack in one great toe. She has passed uric acid in great quantities, although for forty years a total abstainer. She very often suffers from sudden sharp pains in her smaller joints. She has had neuralgia much, but never sciatica or lumbago. She has a well-marked arcus senilis. Her finger-nails are hard, bright, and polished (the nails of gouty persons). She considers that she has a weak heart; her lips are a little dusky. She never drinks tea, as it would, she thinks, make her heart uncomfortable and give her flatulence. She has been all her life exceedingly thirsty, needing to drink large quantities of water even soon after breakfast. She takes much lemonade, and formerly used lime-juice much. Although she has borne a large family and led an energetic life, she has always been dyspeptic, and often ailing. She has had several attacks of what has been called "gouty bronchitis."

The interesting point in Mrs. F——'s case is that she has become liable to attacks of arthritic inflammation of her eyes. The first was nine years ago, and she has had more than she can count since. The eyes become congested, "blood-red." Of late there has been severe pain "like a knife cutting into the eye." In her early attacks the pain was not great, and used to disappear when the congestion developed. Now the pain persists during the whole attack, and usually lasts a week. These attacks are apparently not iritis, for no adhesions have formed, nor are there any uveal deposits on the surface of the lens. Her pupil dilates well with atropine, but is not quite round. The structure of the iris is brilliantly distinct. There is no increase of tension. She sees well, but the eyes easily ache, and become hot if she reads long. She is hypermetropic as well as presbyopic, and some changes are commencing in the direction of cataract.

## DISEASES OF THE NERVOUS SYSTEM.

No. XLIII.—*Liability to violent sick-headaches, from girlhood, with great coldness of feet—Early and profuse menstruation—Early marriage—Liability to neuralgia in right fifth nerve at the age of 25; at first paroxysmal, but afterwards constant during many years—Optic neuritis (double), with attacks of temporary blindness—Deafness in right ear—Recovery of health with persistent and most severe neuralgia, but without any evidences of aggressive cerebral disease.*

The following narrative contains the particulars of one of the most severe cases of neuralgia that I have ever known. The patient was under the care of my colleague, Mr. Tay.

The pain affected the distribution of the right fifth nerve, and when I saw the poor woman it had been continuous night and day for several years. She described it as a shooting, stabbing pain of excruciating severity, comparing it sometimes to a sewing machine at work in her face. Although continuous it had exacerbations, and these latter usually occurred every few minutes. She believed that she rarely slept more than a quarter of an hour at a time, but now and then, when utterly worn out with suffering, she has slept for two hours together.

The following are the notes which I took at the time (about ten years ago). During the night she asserts that she hears all the hours strike. She believes she usually feels the pain during sleep, and does not “quite lose herself.” The pain has never, until quite recently, crossed the middle line in the least, but latterly she thinks it is extending to the

other side of the lip. She does not appear to know in the least the position of special nerve trunks, but says the pain is all over the side of the face, in the cheek-bone, forehead, &c. The slightest touch will bring it on, and she dreads any accidental contact with the skin, lips, or tongue. She used formerly to dread to eat or drink, but latterly she has found that, after bearing the first pain, she could continue to eat in tolerable comfort. Sometimes it has been fancied that the face, forehead, &c., were a little swollen. Her history of her affliction is the following :—

She is now aged 42. She was married in early life (aged 19), and had for some years much mental anxiety and trouble. She was not strong, but had no special illness. Menstruation was always too profuse and too frequent. At the age of 25 she was suddenly attacked by violent shoots of pain in the right side of the face, so severe that for a moment she thought she had been struck. These shoots continued to recur whenever the cheek was touched. She became liable to attacks of this neuralgia, which used to last a few days and then she would have several weeks intermission. In 1857 (aged 27) she for the first time became pregnant, and during her pregnancy, although not free from neuralgia, she was better than before. She suckled her child for thirteen months, but only in part. During lactation the neuralgia was bad, but not so bad as since. Her husband now failed in health, and after a long illness he died in Guy's Hospital in 1859. Soon after this occurrence she became much worse, suffered from attacks of violent vomiting, and found her eyesight gradually failing. It should be stated that she had all her life been liable to most violent attacks of sick-headache. It appears that the failure of sight was slow. She was liable to attacks of total blindness, which would last for a few minutes at a time; these were attended by a sensation of loss of power generally. The attacks of blindness occurred sometimes four or five times a day, and the liability to them lasted several weeks. She was often when walking-out obliged to lean against a wall or get hold of a railing. Any little excitement brought on these attacks. She kept a stationer's shop, and often the mere fact of a customer coming in would cause her

such horrible pain in the eyes and forehead that she became blind, and had to hold on by the counter. After seven months she relinquished her shop and obtained a situation with a lady as companion; a month later, however, she had to relinquish the latter owing to the state of her sight.

After this she was for ten months under Mr. France's care with diagnosis "Amaurosis with cerebral symptoms," subsequently she was under Mr. McMurdo, Mr. Sydney Jones, and Mr. Croft at St. Thomas's. Her left eye had rapidly become so blind that she could only discern light with it, but the right, although very defective, still retained sight enough to be able to read large print. Muscæ and coruscations of light before the eyes were amongst her symptoms.

Her neuralgia for some years was subject each year to a three months' period of remission, during which she was almost wholly free. She does not think that the weather influenced it, but the remissions usually occurred in winter. When free from neuralgia she was liable to severe aching in all her limbs, in the muscles and bones. She thought these pains rheumatic. They were a good exchange from the neuralgia, for they occurred only in the night when warm in bed, whilst the former was continuous. She has had occasionally joint-aches, but has never been liable to any definite form of rheumatism. She does not inherit rheumatism. Her mother died young of consumption. Her father is living and aged, and suffers a little from rheumatism. Both parents were remarkably nervous. Her mother had nervous deafness, and used, under any excitement, to become quite deaf.

Amongst other symptoms which should be mentioned are *deafness in the right ear*. She believes that this came on at the time that her sight failed, and it was attended by constant noises, singing, ringing, &c., in the ear.

*Liability to pins and needles in the extremities*.—This symptom has occurred frequently in all the limbs, and has often been attended by cramp. For some years past her right arm has been especially affected by these sensations and by numbness. Often for weeks together it is never free.

*Extreme coldness of feet*.—All her life she has been liable to cold feet, but latterly more than usual. They are never

comfortably warm, but either—what is usual—as cold as ice or burning intensely.

She has not been nearly so liable to sick-headaches since her sight failed as formerly. She now takes beer and it does not disagree.

On the dorsum of the right foot she has a little round tumour the size of a pea, very probably a neuroma.

Present condition, October, 1871. The left eye diverges considerably. Both pupils are rather large, the right acts fairly, the left scarcely at all.

She is florid and looks in good health, but constantly carries her head stiffly, or a little on one side, to mitigate her pain.

Both optic discs are grey-white and dirty. The margins are notched, and the choroidal epithelium at their margins is much disturbed. The vessels are much reduced in size, both veins and arteries. The atrophic changes are more advanced in the left than in the right disc.

She allowed me to examine the face by pressure in various parts, stating that sometimes she could bear it, sometimes not at all. She had no special susceptibility over the principal nerve trunks.

Her appetite and digestion are fair, and her menstruation regular, and in spite of the persistence of her pain she manages to do some household work, moving always very deliberately. Weather and season exercise no influence on her pain.

Quinine has never done her any good. Opium will procure her sleep, but leaves her in great discomfort next day, so that she dreads it.

Her father had a few years ago an attack of neuralgia in the face.

She is better when out and moving about. Heat to the feet aggravates the pain immediately after its removal. She is very liable to flush after food.

It is interesting to speculate in this case as to the character and probable position of the organic disease upon which the neuralgia and other symptoms have depended. More than ten years have passed since the acute neuritis of the optic nerves

and the development of deafness on the neuralgic side might have seemed to indicate rapidly advancing mischief. Yet no advance has taken place. The cerebral symptoms are now almost in abeyance, and the neuralgia which persists has not passed into paralysis. That the cause is central may perhaps be inferred.

No. XLIV.—*Double optic Neuritis found in a case in which no Eye-symptoms had been complained of*  
—*Detailed description of a headache attending syphilitic gummata.*

Few cases could better illustrate the importance of the routine use of the ophthalmoscope \* than that of Mr. W——. This gentleman, in the third year after a second attack of syphilis, was under my care for periosteal pains in his shins, but without any definite node. He had also a sore nose. I gave iodides, and his symptoms soon disappeared. This was in June and July. He left off the remedies, and in September took his holiday and did some shooting. In October he returned to me, saying that on two occasions during his month's holiday he had suffered from pain in the back of his head, with dulness of energy and great tendency to sleep. On each occasion a few days' use of the iodide had cleared his head and made him comfortable. He made no complaint whatever as to his sight, and he was engaged all day in reading and looking at figures. As a mere matter of rule, however, I examined his eyes, and with the result of finding both discs much swollen, the trunks of vessels concealed, and the choroidal rims blurred. I now tested his vision, found that he could see  $\frac{20}{20}$  with R, and  $\frac{20}{30}$  with L. He admitted when pressed that he had thought his sight not quite so good as formerly, and had on several occasions experienced a little dulness on rapidly rising from his seat.† He was, when I saw

\* Dr. Hughlings Jackson was, I believe, the first to insist upon the importance of this practice, and especially to point out that a patient might be alleged to have perfect sight whilst yet the subject of optic neuritis.

† The temporary loss of sight on rising into the erect posture, as a symptom in cases of optic neuritis with good vision, is the subject of a note at page 184 of my last number of ARCHIVES. It is, I think, of some diagnostic importance.

him, cheerful, energetic, and voluble. He had quite relieved his headache by the iodides.

I thought it a good opportunity for recording the experience of a very intelligent patient as to the kind of headache from which he had suffered. He told me that the pain had been chiefly in his neck, but that it had extended to the back of the head. It had been very severe, but had never prevented sleep. It had been of a tensive kind, but attended also with pricking and sense of heat. In spite of it he had on several days continued his partridge-shooting, beer-drinking and smoking. The discharge of his gun did not make his head worse, and he added, "I shot well." He stated, however, that he did not enjoy himself in the least, was merely dragging himself about, and was exceedingly tired when he got home. On several days he had gone to bed at eight, being unable to keep awake, and had slept twelve hours. His headache was always ready for him when he awoke, though it never in the least kept him awake. He had no sickness, but had a poor appetite, and often felt giddy, especially on rising from his chair. He had never lost his ability to read, but on some days had been obliged to let his newspaper alone, because the reading of it oppressed his head, and as he said, "I could not remember one line when I was reading the next." The skull bones were often very tender to the touch, but no swelling had been ever found. On two occasions, as I have already stated, three days' use of his iodide mixture sufficed to restore him to comfort. It will be seen that the symptoms described were most probably due to the presence of meningeal gumata. The condition of the optic discs made this diagnosis almost a matter of certainty, and it was supported by the fact (twice observed) that the symptoms soon returned when he left off his medicine.

## MISCELLANEOUS.

### No. LXXIX.—*On Enlargement of the palatal glands.*

On the membranes covering the hard palate just anterior to its junction with the soft, there are a number of embedded glands. These are liable to hypertrophy, and become conspicuous as red points. At the same time the rest of the surface may become white, which makes the glands more conspicuous. They extend forwards, as large patches, right and left of the middle line, the latter being exempt. The form of each group is that of an obtuse cone, the base of the cone being the junction of the hard and soft palates. The soft palate remains florid and moist, and contrasts strongly with the white and comparatively dry areas which I am describing. The white condition extends outwards on the hard palate to the gums, but it never extends inwards so as to meet and join with the group on the opposite side. Very often a few isolated but very large glands are to be seen in advance of the apex of the conical group.

I am interested in describing these conditions, because they often, when discovered by the patient, or his medical attendant, give rise to needless anxiety. I have been consulted by several patients who believed that the glands were morbid growths, and of a dangerous nature. They are, I think, more common in the mouths of smokers than in others. They often cause a feeling of roughness appreciable to the fingers of the surgeon, or to the tongue of the patient.

### No. LXXX.—*On the ease with which fæcal or urinary retention may be overlooked.*

Improbable as it may seem, it is yet quite true, that the sensations of the patient are often no trustworthy guide as

to the fulness or otherwise of the rectum or bladder. A patient will often declare "I have no difficulty whatever with my water," when yet his bladder is habitually full. In states of atony the ordinary sensations which attend distention are not produced. It is the same with the rectum and colon. Patients will assert that they have no constipation, "rather, indeed, the other way," when yet the rectum is blocked by a huge hardened mass, by the sides of which motions pass, which they consider adequate, and which may be fluid. Only those surgeons who are resolute in their efforts to secure objective symptoms, and make it a habit to avail themselves of all suitable excuses for digital examinations, can be aware how frequently, and often how wholly unexpectedly, such conditions are met with. Accumulations in the colon are probably quite as frequent.\*

No. LXXXI.—*The effects of Fever in removing chronic ailments.*

The effect of a severe illness, attended by fever, in removing some chronic ailment, is not unfrequently observed. Nor are such illnesses by any means always observed to be in the end injurious to the general health. In a cotemporary biography of John Wesley, I find it recorded that two or three fevers from which at different times he had suffered, "seemed rather to have strengthened than impaired his constitution." He had also suffered from hydrocele, for which he had been several times tapped. "In June, 1775, being seized in the north of Ireland with a severe fever, it effectually cured him of this complaint."

No. LXXXII.—*Inheritance.*

We must, of course, draw a strong distinction between inheritance of a disease and of a tendency to a disease. In

\* In the notes of a post-mortem on a patient under the late Mr. Hewson's care in the Lock Hospital, Dublin, I find it stated: "The condition of the large intestines in this female was very remarkable. The quantity of knotted feces which occupied the intestinal pouches was almost incredible, and this their condition the more claims attention when it is known that alvine evacuations had been regularly maintained during the whole time of the residence of this patient in the hospital."

the case of cancer it is probably, almost invariably, the inheritance only of proclivity; in the case of syphilis and smallpox it is probably the disease itself in the form of germinal matter which passes from parent to child. It may be so occasionally in the case of cancer, and then we must expect the disease to show itself very early in life.

No. LXXXIII.—*High and narrow palate in a tall person.*

Is the height of the palate usually in any ratio with the height of the individual? I have just seen a gentleman of six feet three inches and a half. He had a most remarkably high and narrow palate. Measured across from bicuspid to bicuspid it was little, if at all, more than an inch, whilst the arch rose an inch and half above a line level with the surfaces of the same teeth. He was a well-developed man of a family remarkable for tallness. I have seen many other examples of high palates in tall persons.

No. LXXXIV.—*Vomiting after Burns a serious symptom.*

A child was admitted into the London Hospital on the 1st of January, 1873, very severely burnt, and died in a few hours. It had vomited soon after coming in. The Nurse of the children's ward, a woman of long experience and of considerable powers of observation, remarked to me that she had only known two or three burnt children, who vomited soon afterwards, get well. She considered it an almost certain sign of a fatal issue.

No. LXXXV.—*Sneezing a sign of health.*

Do those who are seriously ill ever sneeze? In other words, may we take the occurrence of sneezing as proof of a degree of vigour and susceptibility on the part of the nervous system incompatible with severe disease? I certainly do not recollect to have ever seen any but fairly healthy persons sneeze. I put the question with especial reference to the widely spread popular superstition that sneezing is a sign of

health and good luck. It is possible that this may have had its origin in the fact that it is for the most part an act restricted to those in fair health. Tylor, who, in his "Primitive Culture," gives some most interesting facts as to the prevalence of this creed and as to certain customs connected with it, traces it in part to doctrines of Animism, but I cannot help thinking that the suggestion I have thrown out may also have some value.

No. LXXXVI.—*A symmetrical eruption of brown stains chiefly confined to the legs in a healthy lad—Persistence for several years, and then gradual disappearance.*

On March 18, 1890, Mr. Felix Stevens, of Stoke Newington, sent to me a boy of 13, who was the subject of an anomalous eruption. It had been slowly developing itself for two years, and he had been for some months under treatment by arsenic. This had been pushed until it disagreed, but had done no good. There was no history of family tendencies, with the exception of gout.

The eruption was confined to the lower extremities, with the exception of a single patch at the back of each ulna. It was accurately symmetrical. It consisted of deep brown stains of irregular shape, which were not thickened, nor were they either scaly or polished. They were not nummular, but somewhat irregular in shape, and varied in size from a sixpence to a crown piece. There was no itching. There were no spots on the trunk.

Two years later (January 26, 1892) I inquired of Dr. Stevens as to what had happened in this case, and I learned that the lad was in good health and almost free from his eruption. As the cure was not attributed to the remedies I need not specify them.

No. LXXXVII.—*An instance of the injurious influence of Arsenic in a Child.*

Another fragment of experience as to the effects of arsenic in young persons is the following: Mrs. H—— brought me

her daughter, a girl of 11, who, amongst other ailments, suffered from psoriasis. She had been, I was told, under the care of Dr. —, naming a very excellent physician, who “had treated her wrongly and made her very ill with arsenic.”

Mrs. H—— said that she had several times remonstrated that the medicine was making the child ill, and Dr. — had always replied that she must go on, as it was the only remedy which could cure the skin disease. “But,” I asked, “did it not cure the skin?” “Yes, it did once,” was the reply, “but it was only when the child was looking very ill, thin, with careworn expression, and darkness around the eyes, and even then the spots came back directly the medicine was left off.”

Amongst other symptoms of disagreement, in addition to these mentioned, the mother stated that the child became whilst under the influence of the mineral very nervous and hysterical. She never had sore eyes nor any fresh form of skin eruption.

Cases such as the above of course prove nothing against the use of arsenic where it agrees. They show only that in respect to it as well as other drugs we must study the idiosyncrasies of our individual patients.

#### No. LXXXVIII.—*On Mercury in the treatment of Jaundice in Dogs.*

On the treatment of chronic liver disease in dogs, Mr. Youatt writes: “The remedy should be some mercurial, with gentian and aloes, given twice in the day, and mercurial ointment well rubbed in once in the day. If this treatment is steadily pursued and a slight soreness induced in the mouth, the treatment will usually be successful.” Mr. Blaine observes: “A moderate soreness of the mouth is to be encouraged and kept up. I have never succeeded in removing the complaint without it.” In the disease referred to it is said that “the skin is usually tinged of a yellow hue, and the urine is almost invariably impregnated with bile.”

In the present state of unsettled faith in drugs, we cannot afford to neglect items of evidence from any witness. It is

not so long since we were told, "as the result of conclusive experiments," that it is a mistake to believe that mercury has any action on the functions of the liver. So far am I from putting any faith in such conclusions, that I look forward with hope to a return of the time when calomel enjoyed the confidence of the public as well as that of the profession. I trust also that not only shall we again believe in the blue pill and black draught and the five-grain-dose of calomel, but that we shall have learned how to use long courses of minute doses. Recent experience in the employment of the latter against syphilis has convinced me that not only do they act specifically against that disease without in the least impairing the general health, but that they very often incidentally cure other maladies. Had we but faith enough to insist upon courses of mercury prolonged for a year or two at a time, I believe that very few need continue to suffer from habitual sick headaches.

No. LXXXIX.—*Note on the prevalence of true Ringworm in London sixty years ago.*

There is a prevalent idea that true Ringworm has much increased in England of late years. Whether it has done so or not is a matter of some interest in reference to our social habits. It has even been suggested—and I think with plausibility—that the disuse of pomades and hair-oils has favoured the easy implantation of the cryptogam. Although it has for long been very common in Paris and some districts in France, it is almost unknown in some other parts of the Continent. As a contribution to the history of the disease in London, the following notes have, I think, their value.

In 1827 Mr. Samuel Plumbe wrote a little essay on "Ringworm of the Scalp, Scalled-head, and other forms of Porrigo." He evidently knew common ringworm well. He speaks of its greater prevalence amongst the better classes, its intractability, and its disappearance as the patient advances in age. He admits that he failed in his treatment often, and says that his patients sometimes went over to Paris; adding, however, that he "never heard of one the better for the journey." His

name for ringworm was “*porrigo furfurans*.” After describing his treatment, he writes:—

“In a few cases these measures have been followed by complete success; but the majority have, from the circumstances mentioned, been ultimately resigned in despair. It is a curious though very consoling fact, however, that a spontaneous disappearance of the disease occurs, in nineteen cases out of twenty, before the age of puberty arrives.

I fear that there are amongst us even now a few medical men of experience (and a much larger number of parents of experience) who would incline to acquiesce in Mr. Plumbe’s candid record as regards results, and to hold that the only real cure for ringworm is to let the patient grow out of it. For myself I may avow my belief that the introduction of Goa powder, and its active principle chrysophanic acid, has supplied us with a new arm of the utmost efficiency. I seldom use anything else, and, with fair co-operation on the part of the nurse, I believe rarely fail.

No. XC.—*Mr. Plumbe’s nomenclature, and his experience as to Favus.*

It is interesting to note that the “*porrigo favosa*” of Mr. Plumbe is not favus, but the contagious disease which, since Mr. Startin’s time at Blackfriars, we have called “*porrigo*,” or “contagious *porrigo*,” in distinction from eczema. It was contagious to the nurses and to other children; it produced heaped-up bad-smelling crusts; was usually accompanied by lice; and usually caused enlargement of the cervical glands.

It may be doubted whether Plumbe had ever seen a case of true favus. I find nothing in his writings to prove that he knew the disease.

The “*porrigo larvalis*” of Plumbe was allied to his “*favous porrigo*,” but affected the face rather than the scalp, and had more of eczematous tendencies. The term *larvalis* was earned when the eruption crust covered the features like a mask.

It is of great importance to note these discrepancies as to the names used, since, unless they are recognised, false im-

pressions may easily be formed as to the prevalence of certain types. Mr. Plumbe's experience as to true favus, or rather his entire lack of it, fits with that of the present time. By general consent true favus is in London, and indeed in England generally, a very rare disease. All statements to the contrary are based on errors in diagnosis. Mr. Malcolm Morris has recently made this point the subject of special investigation.

No. XCI.—*On differences in Temperature between Fingers on the same hand after division of the Ulnar Nerve.*

I believe that I have myself had some credit accorded me for an early record of observations on differences in the temperature of the fingers after nerve sections. The subjoined extract, which I take from an old Medical Journal and which was published soon after Sir Astley Cooper's death, shows that this subject had not only attracted his attention, but that he had endeavoured to make exact observations on it.

(From Sir Astley Cooper's Note Books.)

“DIVISION OF CUBITAL NERVE.

“I saw a girl, who had, twelve months before, divided the cubital nerve by a piece of glass, and just above the elbow. The glass was removed, the wound healed, but the girl had lost all sensation in the little finger, and partly in the finger next it. The finger was perfectly dead to sensation; it appeared purple, as did the back of the hand towards the little finger; it felt cold, and, upon the application of the thermometer, was found to be eight degrees below that of the middle finger of the same hand. Middle finger, 86°; little finger, 78°. She could move this finger. The nail also grew upon it, though not in proportion as upon the others.”

I have much pleasure in reprinting this, not only as a measure of justice to the memory of a great surgeon, but as a contribution to the history of the clinical use of the thermometer. Hunter himself more than a century ago devised a modified instrument for biological research and figured it. It is not improbable that he used it at the bedside also, but I do not know of any proof that he did so.

No. XCII.—*Congenital defect of sight in three children of a family of four—Almost amounting to blindness in infancy, but with gradual improvement in childhood—Nyctalopia—Nystagmus—No other defect of the nervous system.*

A very interesting series of cases illustrating family defects was brought to me by Mr. V——, of Winchmore Hill. They were the three children of Mr. and Mrs. C—— of that place. E——, the eldest, aged 13, had very defective sight, and concerning her, as well as of all the others, it was asserted that she could see only in bright light, and not at all in the dusk. Her sight was believed to have been defective from birth, and she had never seen well enough to learn to read. At the age of four she had been examined by an able ophthalmic surgeon, Mr. Waren Tay, and a very unfavourable opinion had been expressed as to her probable future. In still earlier infancy she had been considered to be blind. Thus, although it was very difficult to estimate the exact amount of sight, either at the present or at former periods, the evidence made it very probable that she was slowly improving, and almost certain that she had gained since infancy. She was slightly myopic, but was not improved by glasses. Her vision was  $\frac{6}{60}$ . There was some nystagmus and alternating lateral deviation of the eyes. The ophthalmoscope showed thin choroids, discs rather pale and blurred, central arteries small, but veins of fair size. There was no trace of pigmentation of the retina.

The next child was a girl named M——, aged 11, who had perfect sight.

The third was a boy named J——, whose sight was defective, just like his elder sister's.

The fourth, an infant of eighteen months, named E——, appeared to be blind in like degree to that of her elder brother and sister, and, like them, supposed to be improving as age advanced.

In the boy J—— the ophthalmoscopic conditions were much the same as those described in his sister, but the changes in the disc were much less marked. He had no

myopia that could be corrected by glasses, and his vision, which was alike in the two eyes, was only  $\frac{1}{60}$ . His field was much narrowed. It is to be understood that the nystagmus which was present in both these cases, although slight, interfered considerably with the measurement of the field, the use of the ophthalmoscope, and the appreciation of vision.

We have, then, three children out of a family of four all affected in a similar manner. In all the eyes presented like conditions, and in none were the conditions apparently adequate to explain the defect. Great thinness of the choroid, but without the slightest trace of retinal pigmentation, and slight changes at the disc, indicative perhaps of imperfect development, or of intra-uterine neuritis, were all that could be found. There was no advanced condition of optic atrophy. None of the three children presented any other defect whatever. In none was there any degree of deafness. They were intelligent, good-tempered, and, making allowance for the want of sight, had got on well with their education. In all the teeth were well formed, and in none was the palate unduly high. The parents had been in no degree related before marriage, nor was there any known history of defective sight in any predecessor. It is of much interest, finally, to note that, reversing what is usually the case in retinitis pigmentosa, there appeared to have been progressive, though but slight, improvement in the defective function.

## A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. CXXXVII.—*Croup and Diphtheria.*

### QUESTIONS.

1. What was Dr. Alison's suggestion in explanation of the fact that in Scotland croup usually sets in during Saturday night?

2. Give other facts in support of the belief that exposure to damp air is often a cause of croup.

3. Is it true that croup usually begins in the night?

4. What was Dr. Cheyne's favourite remedy for croup?

5. At what stage of croup should the cure by the use of antimony be attempted?

6. Distinguish between emesis and nausea as to their beneficial effects in croup.

7. By what actions is it likely that antimony may prove beneficial in diphtheritic inflammations?

### ANSWERS.

1. It is customary in Scotland to wash the house on Saturday afternoons, and from the damp thus produced the youngest children often get diphtheritic sore throat (croup).

2. Diphtheria is constantly observed to prevail in damp localities, and in the lowest lying parts of large towns. The banks of rivers and seaside places have long been reputed to suffer much from croup.

3. It is very usual for the more acute symptoms of croup to begin suddenly in the night. The child waking up with crowing respiration and difficult breathing. In most cases, however, there has been some degree of premonitory hoarseness and sore throat.

4. Antimony ; which he used in large doses, and continued long. A good prescription is one grain dissolved in an ounce of boiling water, and the solution given in a dose from a tea- to a dessert-spoonful, according to the age of the child, every half-hour. The mixture is to be disused when sickness is produced, but resorted to again, after an interval, if necessary. The patient should also be put into a hot bath.

5. The earlier the stage, the more suitable is the case for the relief by antimony. Most cases in the first stage may be cut short by it. In the later stages ipecacuanha wine is a safer remedy.

6. It is possible to produce a prolonged condition of nausea without actual vomiting ; and, on the other hand, it is possible to cause sudden vomiting without much long-preceding nausea. The one or the other effect may be obtained by modifications of dose. Long-continued nausea is attended by very considerable depression, much greater than that which results from the action of an emetic.

7. Antimony may be used either as a nauseant or as an emetic, and is useful in both directions. During the state of nausea there is much less tendency to fibrous effusions and an increase of fluid secretions. Thus the membranes may be loosened, and the subsequent occurring of vomiting may favour their ejection. It is well known that cases of diphtheria with dry surfaces are the most dangerous, and thus the action of antimony in favouring transudation of fluid may be very valuable.

### No. CXXXVIII.—*Uses of Antimony.*

#### QUESTIONS.

1. What is the proper dose of tartarised antimony when given to an adult to counteract an acute inflammation ?
2. Are the effects of antimony tolerably uniform ?
3. What are its most marked effects ?
4. Is it a safe remedy for children and delicate persons ?
5. Should it be given before or after food ?
6. Has antimony any definite effects in cases in which it does not produce nausea.

7. What is the chief difference in action between antimony and ipecacuanha ?

8. Is it a reasonable statement that ipecacuanha " is somewhat depressing to the system, but less so than tartar emetic " ?

#### ANSWERS.

1. A good rule for the use of antimony is to prescribe always one-sixteenth of a grain, and to give the dose every hour or less frequently according to the effect desired.

2. They are very uniform. You may rely with confidence upon the sequence of certain results.

3. The constant result when the remedy is pushed is a feeling of nausea and slight faintness. The face becomes pale, and there is a tendency to perspire. Vomiting and diarrhoea, with entire temporary failure of muscular strength, may follow.

4. It is quite safe if given cautiously in small doses with the direction to stop its use as soon as nausea is felt.

5. It should always be given on an empty stomach unless it is definitely wished to avoid its nauseant effect, and possibly to render it useless.

6. It is very difficult to feel certain on this point, but probably it does favour the equable distribution of blood, and the secretory functions of all glands.

7. Ipecacuanha may be called vegetable antimony, for the effects of the two are very similar. Ipecacuanha is, however, more prone to cause vomiting without the intervening stage of nausea, and it is impossible to produce even with large doses the profound depression which results from antimony.

8. Such a statement is for the most part meaningless since everything depends on the dose. Tartar emetic may be given in such doses that it is a tonic and not a depressant at all. If, however, the two drugs be pushed to nausea, then it is true that the nausea of ipecacuanha will be attended by less influence on the vascular system and muscles than that of antimony.

No. CXXXIX.—*On Prescribing Antimony.*

## QUESTIONS.

1. In what doses may tartarised antimony be given for chronic disease where it is not desired to nauseate?
2. How long may it be so used, and what are its effects?
3. For what diseases would you so prescribe it?
4. What conjecture may be offered in explanation of the influence of antimony in improving the appetite?
5. What are relations of antimony and opium to each other? Under what conditions of disease would you combine them?

## ANSWERS.

1. A sixteenth of a grain given three times a day will rarely occasion nausea, and may be continued for many months with the usual effect of improving the appetite and health. These doses often appear to much diminish irritability and congestion in the skin and the mucous membranes. Patients acquire tolerance of antimony, and the dose may in some cases be increased to one-eighth or a quarter of a grain.
2. It may be used for many weeks or months, or, indeed, quite indefinitely.
3. It appears to have very good effects in chronic congestion of the skin and mucous membranes. It is especially adapted for those in whom there is a defect of secretion. Thus chronic eczema or seborrhœa, are often very much benefited by it. It also abates irritability in all pruriginous affections. In some cases of lichenplanus it appears to have an almost specific action.
4. It may act by diminishing local congestions and general febrile irritability. As it favours glandular action it may increase the secretion of the gastric juice.
5. Opium tends to diminish the depressant effects of antimony, and to some extent it possibly prevents its action in general. The combination of the two, however, in states of irritability attended with local congestions is often admirable in its effects. When antimony is given to aged persons, especially to those who are weak, it may generally be combined with a little opium.

No. CXL.—*On Prescribing Antimony.*

## QUESTIONS.

1. Why should tartarised antimony be given on an empty stomach, or at any rate not immediately after food?
2. With what drugs is antimony incompatible?
3. What plan of diet should be enjoined during the use of antimony?
4. What is the meaning of the old word antiphlogistic?
5. In what respect is tartarised antimony superior to all other forms of the metal?
6. How is it best prescribed?
7. What is the strength per drachm of antimonial wine?

## ANSWERS.

1. Antimony forms an insoluble compound with astringents and with alkalies and their carbonates. It is, therefore, very possible that it may be neutralised by various articles of food. The direction to take the dose after meals may easily be equivalent to not taking it at all.

2. Bark, rhubarb, tannic, and gallic acids must not be combined with antimony. Thus a favourite prescription of a late distinguished ophthalmic surgeon of tartarised antimony in tincture of bark was probably equivalent to giving bark alone.

3. If antimony be used with the hope of checking an acute inflammation, all stimulants and tonics should be avoided, and a distinctly low diet should be enjoined. It is quite possible, however, that in chronic cases antimony may exercise some good influence when taken in conjunction with ordinary diet.

4. The term antiphlogistic was formerly in common use for any method of treatment which tended to restrain inflammatory action and to reduce local congestions. A great number of remedies acting in different ways come into this class, but the most typical and efficient of them all is probably antimony.

5. Tartarised antimony is preferable to other preparations on account of its easy solubility.

6. It is best prescribed dissolved in water (boiling at the time), and with the addition of a little mucilage to secure suspension. No other drug should be combined with it.

7. A teaspoonful contains a quarter of a grain. Antimony is only imperfectly soluble in wine, and its solution in water only is more certain to be uniform.

### No. CXLI.—*Elephantiasis.*

#### QUESTIONS.

1. What clinical varieties in elephantiasis may we recognise?

2. Is there any definite distinctions to be made between elephantiasis as seen in temperate climates, and when endemic in the tropics?

3. What influences probably explain its endemic prevalence in hot countries?

4. What is known as to its probable association with the *Filaria sanguinis*?

#### ANSWERS.

1. A great number of clinical groups of elephantiasis might be constructed in relation to different states of the patient's health, the part affected, and the exciting cause. Attacks of erysipelas occurring in dependent parts—the leg, for instance—are its common exciting causes, and the recurrence of repeated but milder outbreaks of the same malady is usually the cause of its increase. We may speak of symmetrical and of unilateral elephantiasis, of smooth elephantiasis and tuberculated form, of sporadic and endemic elephantiasis, but it is to be understood that fundamental to all these is the liability to recurrent erysipelas with its attendant solid œdema.

2. Elephantiasis is common in the tropics, especially in some regions, whilst it is rare in England. It is often symmetrical as seen in the tropics, and it is almost invariably restricted to one limb, as witnessed in England. We may infer, therefore, that constitutional influences take a much greater share in its production in countries where it is endemic than is the case in temperate climates. These influences are great heat, a moist atmosphere, and the presence



PLATE LXVI.  
SOLID ŒDEMA OF THE EYELIDS.



THIS plate shows the portraits of two women who were the subjects of that form of solid œdema which not unfrequently occurs as a result of repeated attacks of an erysipelatous swelling of the face. The disease may occur at any age, but is more common in adults than in young persons, and produces, as a rule, more conspicuous deformity in women than in men. I have published on different occasions a considerable number of examples of this malady. The usual history is that the patient has been liable for years to recurring attacks of erysipelas, transitory in duration and limited to the face, but attended with very considerable œdema.

The final condition is one allied to Elephantiasis. The disease is wholly local.





of malaria. Elephantiasis is, however, essentially the same disease in all countries, and in the sporadic cases seen in England the conditions are often as highly developed as in the worst tropical cases. There are, therefore, no definite distinctions to be traced.

3. All influences which tend to degrade the vigour of nutrition may increase the tendency to elephantiasis and favour its development when once begun. Thus heat, moisture, and malaria are in turn and in combination all influential.

4. Although in tropical patients the filaria is commonly found in the blood of elephantiasis patients, yet as it is absent in cases seen in temperate climates which are exactly the same in character, it is impossible to assign to it the rank of a true cause.

#### No. CXLII.—*Fatality of Exanthemata in relation to Age.*

##### QUESTIONS.

Miss Yonge, in one of her interesting novels, has depicted the misfortunes of a high-born curate who, during his early life, had been sedulously guarded against all risk of contracting children's diseases. Entering zealously upon his parochial duties he was laid up in turn with whooping cough, measles, chicken pox, and scarlet fever. The lesson which the reader is intended to draw is (in conformity with a wide-spread belief) that it is better to get these maladies over in childhood. How far is such a belief justified by facts?

1. Is the fatality of scarlet fever greater in childhood or in adult life?

2. Does the mortality from small-pox differ at different ages?

3. Are all forms of fever more fatal in infancy and early childhood?

4. How are the facts in reference to diphtheritic inflammations (diphtheria)?

##### ANSWERS.

1. The fatality of scarlet fever is far greater in early childhood than it is in adults. Thus whilst under the age of two years

it may average 30 per cent., and between the ages four and five as much as 12 per cent., after the age of 15 it scarcely reaches 5 per cent.\*

2. The mortality of small-pox is greater during the first two years of life, after that it diminishes until adolescence, when it again increases.

3. The fatality of diphtheria is most definitely ruled by age. The younger the patient the more severe the disease, the more difficult the treatment, and the greater the risk of death.

4. It is a very remarkable fact that typhus fever is scarcely ever fatal in infants and young children, whilst it is very dangerous in adults past middle life.

### No. CXLIII.—*The Tongue.*

#### QUESTIONS.

1. How many kinds of papillæ are there on the tongue?
2. Of what does the "fur" on the tongue consist?
3. In what conditions is it common for fur to accumulate?
4. How do you explain unilateral fur?
5. What is meant by an "indented tongue"?
6. If one lateral half of the tongue be wasted and flabby, what lesion would you suspect?
7. How would you test the state of the tongue as regards paralysis of the hypoglossal nerve?
8. What is the clinical significance of an indented tongue?

#### ANSWERS.

1. Three—filiform, over whole surface; fungiform, at sides and tip; and circum vallati, or calyciform, eight or ten in number at base. All these papillæ are compound, *i.e.*, covered with simple ones, and in addition to them are numerous minute simple ones more or less buried in the epithelium.

2. Accumulation of epithelial scales on the papillæ.

3. Whenever the tongue is not used in the mastication of solids fur may be expected to collect. Thus it is a symptom

\* These figures are taken from the statistics of The Metropolitan Asylums for 1890, page 11, and are based upon nearly 37,000 cases.

of want of appetite in general. It is, however, liable to much modification in connection with personal peculiarities.

4. Unilateral fur implies that its subject masticates chiefly or solely on one side of his mouth. The side of the tongue on which he eats will clean and the other remain coated. Thus it may imply want of teeth, or toothache, or one-sided paralysis.

5. A tongue, which, being soft and somewhat cedematous, has received at its edges the marks of the teeth against which it has pressed.

6. Paralysis of the hypoglossal nerve. The wasting is of substance of the lingualis muscle.

7. Take the two sides of the tongue between the finger and thumb of each hand, and then direct the patient to forcibly thrust the tongue out of the mouth. The non-paralysed side will at once become hard and the other remain soft and flabby.

8. It is often little more than a personal peculiarity. It may be a relic of a former salivation. It may imply general want of tone and tendency to cedematous state of the solids.

### No. CXLIV.—*The Cremaster Reflex, &c.*

#### QUESTIONS.

1. What is meant by the cremaster-reflex?
2. At what age is it most vigorous?
3. Under what conditions is it absent or diminished?
4. How is it produced?
5. How is the cremaster innervated?
6. At what part of the back does the spinal cord end?
7. How is the sphincter ani supplied by nerves?

#### ANSWERS.

1. On sharply tickling or scratching the inner part of the thigh the testicle is drawn up. This is called exciting the cremaster-reflex.

2. It is most vigorous in boys or in early adolescence.

3. It is absent in aged persons and in states of sexual debility and neurasthenia, also in tabetic affections.

4. It is due to the anatomical fact that this region of skin is supplied by the same nerve as that which gives motor power to the cremaster.

5. The cremaster muscle is supplied by the genital branch of genito-crural, which is derived from the second lumbar. The crural filaments of the same are distributed to the skin of the upper and front part of the thigh.

6. The spinal cord ends and the cauda equina begins at the first lumbar vertebra.

If the genito-crural tract of skin on front of thigh has escaped sensory paralysis, as proved by the possibility of exciting the cremaster, then we may be certain that the disease or injury is below the level of origin of the second lumbar nerve. This applies, however, only to recent injuries and to disorganising disease, for the reflex functions of the cord may be recovered after a time below a well-localised lesion, and may even be in excess.

7. The external sphincter ani is supplied from the lower part of the sacral plexus by filaments derived from the pudic thigh, the inferior hæmorrhoidal.

It is probable, however, that it is the internal sphincter which is the chief means of the retention of feces under ordinary circumstances, and that the external sphincter is employed only in volitional contract. The internal sphincter receives its supply chiefly from the vaso-motor, and may be efficient when the other is lost.

### No. CXLV.—*The Urine, &c.*

#### QUESTIONS.

1. What is the normal rate of respiration?
2. What quantity of urine should a man pass in twenty-four hours?
3. With what other function is the quantity of urine usually in relation?
4. What is the state of the skin in diabetes?
5. Is the urine more freely secreted during sleep or when awake?

## ANSWERS.

1. Fourteen to eighteen per minute.
2. In summer thirty ounces, and in winter forty ounces.
3. With the activity of the skin. If there be much perspiration there will be but little urine.
4. Almost invariably dry.
5. It is much diminished during sound sleep, and increased when awake, as any one may observe who will relieve his bladder as soon as he wakes after a six hours' sleep, and then remain in bed, awake, another hour.

No. CXLVI.—*Hemicrania*.

## QUESTIONS.

1. What are the more common symptoms of hemicrania ?
2. Is the pain in the skin ?
3. Does it always prevent sleep ?
4. Is the pain intermittent ?
5. Does any affection of muscles ever attend hemicrania ?
6. Are there any special disturbances of function ?
7. What is the usual effect of stimulants and food ?
8. Does the pain often change its place ?

## ANSWERS.

1. A severe, persistent, tensive pain or ache in one frontal region. The pain is aggravated by motion of the head, and compels the patient to hold his head still with the utmost care. Sometimes "shoots of pain" occur, but this is not a common or prominent feature. There is tenderness on firm pressure over the painful parts, and especially upon and under the margin of the orbit. Although there is a degree of tenderness, yet the painful part bears firm pressure, and is sometimes even relieved by it.

2. The tenderness is not in the skin, but deeper, in the bone or periosteum. There is often slight swelling of the eyelids and of the parts beneath the eyebrow.

3. The pain does not usually prevent sleep.

4. The pain often recurs every day, and comes on at the

same time in each day. Very often it comes as soon as the patient leaves his bedroom.

5. There is usually some lachrymation, which is aggravated by exposure to artificial light or by attempts to read. The attempt to use the accommodative function is always painful—hence the difficulty in reading.

6. In very bad cases there may be some defect of power in the muscles of the side affected. Partial ptosis or spasmodic contraction of the orbicularis or of the muscles of cheek.

7. Food and stimulants sometimes produce temporary relief.

8. The pain, although fixed usually to one side, may now and then change about. Not infrequently the occiput is affected, or the mastoid region, and sometimes the opposite forehead.

#### No. CXLVII.—*Use of Setons in Eye Diseases.*

##### QUESTIONS.

1. What are the indications for the use of setons in diseases of the eye?
2. Where should the seton be put?
3. What is the special risk?
4. What material should be used for the seton?
5. How long should the seton be left in?

##### ANSWERS.

1. They are to be used in cases of corneal ulceration which are intractable under other methods, and more especially if they are attended by pain. In such cases they are of the utmost value.

2. In the skin of the temple, well back amongst the hair so that the scar left may not be seen.

3. There is risk of wounding a branch of the temporal artery with the seton needle. The bleeding is sometimes very troublesome.

4. Two strands of thick silk are sufficient, or if the thickest be not at hand four of a medium size may be used.

5. A month or six weeks—that is, until the eye is quite well.

No. CXLVIII.—*Tumour of Face and Neck.*

## QUESTION.

From the appearance of the swelling represented in the woodcut, taken in connection with the age of the subject, what would be the conjectural diagnosis as to the nature of the disease?

## ANSWER.

The patient is a child; the swelling bulges largely on the cheek, and less so in the posterior triangle of the neck. Neither its form nor its position are those which are usual in strumous disease of the glands. Nor does the tumour on the face keep to the position of the parotid gland. It is, on the other hand, in a position in which congenital nævoid and cystic tumours are not infrequent. The tumour was probably of this class. These growths, although present at birth, are liable to increase in the first few years of life, and are also prone to attacks of inflammation, during which they swell up to a large size. These inflammations may be attended with sharp constitutional disturbance, and may even end fatally; more usually, however, they subside after a few weeks, and the tumour then shrivels, leaving the skin flabby

and loose. [Such was the course of the disease in the case of the patient whose portrait is here shown.]

### No. CXLIX.—*Foreign bodies in the Ear.*

#### “A SURGEON CENSURED.

“At Innspruck in Tyrol a young man got a caroub-bean shoved into his ear by a mischievous boy. The bean swelled and gave the patient some pain, which caused him to visit a doctor for the removal of the foreign body. The surgeon attempted the removal of the bean by means of a curved probe, and during the process of extraction he somehow broke the drum of the ear. Acute inflammation of the middle ear and tympanum was set up, and the patient died in excruciating agony seventeen days after the accident. The surgeon was censured for his want of skill by the Faculty of Medicine of Innspruck, and required to submit to an examination in surgery before he be allowed to again practise.”

#### QUESTIONS.

1. Was the censure of the surgeon under the circumstances described in the above paragraph deserved?
2. What answer ought he to be expected to give, at his second examination, as to the treatment appropriate for such a case? \*

#### ANSWERS.

1. A bean is, on account of its liability to swell with moisture, one of the most difficult of all substances to extract with safety from the ear. Many patients have died from the efforts of the surgeon in such cases. There is in the museum of the London Hospital the temporal bone of a child who died precisely under the circumstances described in the extract. The censure and the sentence were, perhaps, too severe; yet should their publication have the effect of deterring others from the use of scoops, bent probes, &c., for the removal of foreign bodies from the ear, they are, perhaps, not to be regretted.

2. He should be required to say that he would in future never use either probes or scoops, that he would always in the first instance employ an efficient ear-syringe, if necessary placing his patient on a high table with the ear looking

\* I hope none of my readers will suspect me of having invented this case. It is true that I wrote very strongly years ago in reprobation of the practice described. The case, is however, copied verbatim from a medical journal.

directly downwards; that his next measure, if the syringe failed, would be the employment of a loop of soft silver wire, to be placed under the foreign body. If—as in the case of an already swollen bean is very possible—both syringing and the wire loop should fail to extract it, it would be safer to desist from further efforts, and trust the substance may soften and come away piecemeal.\*

No. CL.—*Detachment of Lower Epiphysis of Femur.*



The appended woodcut shows a clean and complete detachment of the lower epiphysis of the femur. The muscles of the leg have been dissected, in order to show the relation of those of the calf to the epiphysis itself. The lower half of the femur has been cleaved, in order better to exhibit the form of its epiphysal end. The specimen was obtained by a primary

\* In 1863 I described and figured the loop of wire to be used for this manipulation. Since then I have employed it repeatedly, and it has never failed in my hands. I have not, however, had to do with swollen beans, and am quite ready to admit that they may occasionally present insuperable obstacles to all safe methods of abstraction. I invariably use the loop of wire if the use of the syringe is not speedily effectual. I have used the loop also for the extraction of foreign bodies from the trachea.

amputation in the case of a boy, aged 14, under my care some years ago in the London Hospital.

#### QUESTIONS.

1. Up to what age is detachment of this epiphysis possible ?
2. Is it usually attended by complete dislocation of the epiphysis from the shaft ?
3. What is the usual displacement of the epiphysis when the dislocation is complete ?
4. How should such displacement be remedied ?
5. Do any specimens exist in our museums illustrating union after this accident ?

#### ANSWERS.

1. The lower epiphysis of the femur may be detached at any age under 20 ; but the accident usually occurs between 8 and 18.

2. Fortunately, the complete displacement of the shaft from the epiphysis is rare, even in cases where the separation is quite complete. The surfaces separated are large, and that of the shaft does not usually leave the whole of that of the epiphysis.

3. If the epiphysis has been completely disengaged from the shaft, the tendency will be for it to be displaced by the gastrocnemius into the position of full flexion at the knee : this is the position which is shown in the woodcut. Much must, however, be allowed for the direction in which the violence has been applied.

4. It may be quite impossible to alter the position of the epiphysis ; the best chance of doing so will be by first effecting reduction, with the knee bent at right angles, and then partially straightening the limb. The treatment of such cases, is however, extremely difficult and unsatisfactory.

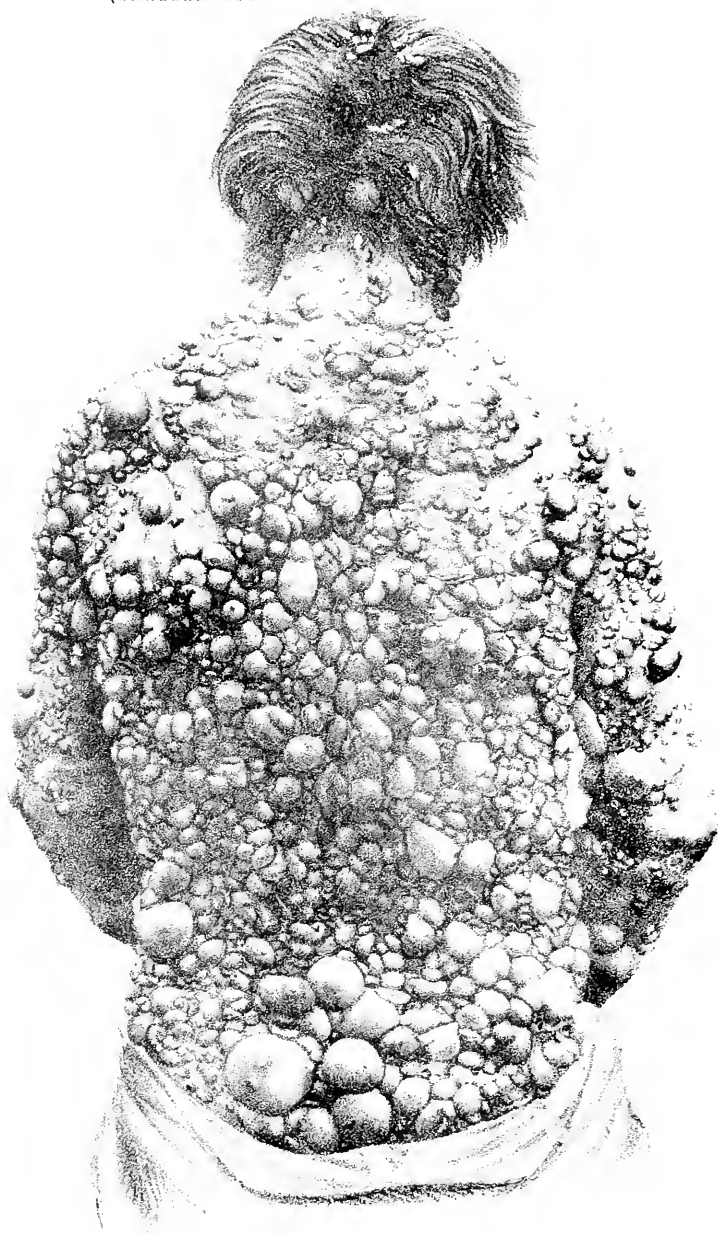
5. Exceedingly few specimens in illustration of this accident, at any stage, are in existence. There is one, illustrating union, in the Museum of the Royal College of Surgeons, from Mr. Liston's collection. It shows displacement of the epiphysis forwards, relatively to the shaft—that is, the reverse of what has just been described.



PLATE LXV.  
MOLLUSCUM FIBROSUM.

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THIS plate, copied from a photograph, shows the present condition of the man Gray, whose face was depicted in Plate LXIV., given in the last number of ARCHIVES. His portrait is also published in the New Sydenham Society's Atlas. These portraits prove that the disease, Molluscum fibrosum, tends to increase as age advances. I possess a considerable number of photographs of molluscum fibrosum patients which have been sent me by friends from all parts of the world. All the patients in whom the disease is severe are in adult life, but, with the exception of these portraits of Gray, I do not know of any which show the condition in the same patient at different periods of life. It is probable that in most, if not in all cases, the tumours continue to increase in size, and multiply in numbers, from adolescence up to middle age. If I were to speak from my own experience and from the evidence afforded by my collection of photographs, I should incline to say that these severe forms of molluscum fibrosum, which go on increasing through a patient's life, occur exclusively in males. I have never seen a severe case in a woman, although solitary tumours are not infrequent. Gray's age is now about 50, and the tendency began to show itself when he was a boy. The first portrait was taken when he was 27.



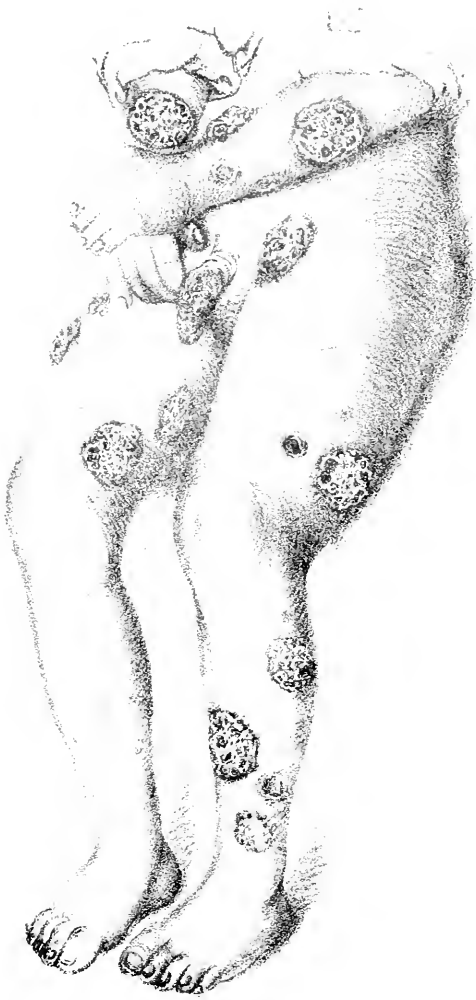
## PLATES LXVII. & LXVIII.

### LUPUS VULGARIS (MULTIPLE).

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THESE two plates represent the lower extremities and fore-arm of the same patient, with an interval of four years. He was a boy of 4 when the portrait, of which Plate LXVII. is a copy, was taken, and was nearly 9 when the other was done. They are to be considered as little more than maps, designed to illustrate the location and size of the diseased patches. It will be observed, on comparing the two, that everywhere the patches have increased in dimensions, and that in many places two or more have coalesced. On the right leg in particular the later sketch shows patches of considerable size, where in the earlier one there were but small spots. The foreskin, which in the earlier portraits is seen involved in disease, had been removed by circumcision before the second one, and the parts were soundly healed.

The disease represented in these figures was *Lupus vulgaris*, occurring in multiple development. Its particular features will be better appreciated by reference to the coloured portraits which form the subjects of Plates LXXVI. and LXXVII., and which represent the same patient. The case, which has already been referred to in my Harveian Lectures on *Lupus*, is that of a boy named L—; his disease, which commenced by a parent patch on one arm, developed itself very rapidly as a generalized eruption of a lichenoid and pustular character, which assumed some of the features of *rupia*. It was not identified as *lupus* until it had been present for a year or more, but it ultimately assumed all the characteristic features of the non-ulcerating form of that disease. The child, who is still living, is still the subject of immense patches of *lupus*. The disease has been throughout too extensive to permit of the efficient employment of local treatment. No advantage was obtained from the use of injections of Koch's fluid. It is of importance to notice that, although in this case the *lupus* occurs as a generalized eruption, the patches being very abundant and on both sides, yet they are not actually symmetrical; in this feature *lupus vulgaris*, however plentiful the patches may be, always differs from the ordinary type of *lupus erythematosus*. The latter is usually, though not invariably, arranged with the most definite symmetry; the former is never so.











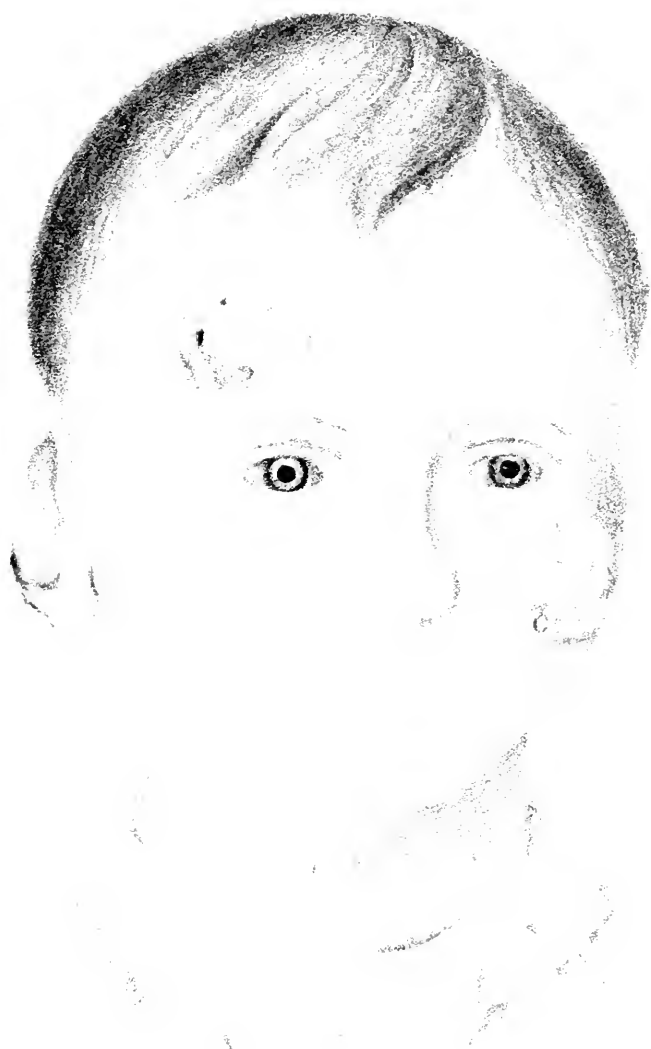
## PLATES LXXVI. & LXXVII.

### LUPUS VULGARIS (MULTIPLE).

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PLATES LXXVI. and LXXVII., which belong to the same case as Plates LXVII. and LXVIII., already described, represent the face of the little boy with an interval of four years, and show well the changes in character of the disease as well as its advance at the borders of all the patches. In the earlier portrait doubts might be suggested as to the diagnosis of Lupus; respecting the later one none whatever can be felt. The portraits are therefore of great value as illustrating the early stage of this disease, and I am not aware that any others of a similar character have as yet been published. The remarks made in the description of the previous plates, in reference to the absence of accurate bi-lateral symmetry in the location of lupus vulgaris, are well illustrated in these portraits.

It may be well to draw attention to a very important fact which these four portraits illustrate, that lupus vulgaris, when once established, does not tend to produce any new patches; its multiplicity is almost invariably attained (if at all) in its very earliest stage. After that, although the individual patches tend slowly to increase in size, and may indeed extend at their margins indefinitely, no new ones are produced.













# ARCHIVES OF SURGERY.

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APRIL, 1893.

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## ON ALOPECIA AREATA AND ITS RELATION TO RINGWORM.

I do not think that any one will read attentively the items of evidence which I am about to produce as to the clinical history of Alopecia, without coming to much the same conclusions that I have arrived at myself. The chief of these conclusions is, that all well-characterised cases of alopecia areata are in direct connection either with ringworm or pityriasis versicolor, and that they have little or nothing to do with the state of the patient's general health. Under the head of well-characterised cases I count all in which the eruption begins as smooth, bald patches which are abruptly margined, which tend to spread at their edges, and are attended by the development of others in their vicinity. Great latitude is to be allowed in reference to the extent to which the falling of the hair progresses. In some cases the patient may lose every hair on the body in the course of a few months, whilst in others the patch may remain single and solitary for a year or more. Differences in the rate or extent of progress do not seem to me to imply any difference in the essential nature of the disease; and I much doubt whether there is any class of cases, in which the shedding of the hair becomes universal, which are not of the nature of alopecia areata.

The condition which is chiefly likely to give difficulties in the diagnosis of alopecia areata is its simulation in syphilis. For the most part, when syphilitic patients lose their hair,

they lose it diffusely, as is the case in senility and after fevers. There is, however, another condition met with in the secondary stage of syphilis which very closely resembles the areate form of alopecia. In this the hair falls in patches. These cases may, however, I think, generally be distinguished by observing that the patches are not nearly so abruptly margined, and that they are not so glossy, nor the skin so thin, as in the non-syphilitic form. There is also usually a thinning of the hair on the rest of the scalp, a feature which is never present in true alopecia areata.

With these preliminary statements I will now proceed to the narration of my cases, reserving further comment for the end of my paper.

CASE 1.—A man named S—, florid, and in excellent health, was under my care in January, 1881, for smooth bald patches of alopecia on the back of head and on his chin; they were advancing. He had five children, and one of them had, not long ago, suffered from ringworm; he believed that his wife had also contracted it from the child, but had soon got well.

CASE 2.—A young man, aged 19, Mr. C—, was the subject of alopecia on the back of his head, in the ordinary form of large smooth patches. The history was that, when a boy at school, he had suffered for a long time from ringworm.

CASE 3.—A lady named F— was brought to me by Mr. F. Mackenzie on account of a tumour in one of her breasts. She had also, however, a large patch of characteristic alopecia, which had formed in the last six months. She was 36 years of age; she had never previously had any alopecia, but she was aware that she had suffered from ringworm in childhood. She stated that she had had several patches, but as far as she could remember none were on the precise site of that now occupied by the alopecia.

CASE 4.—The connection between ringworm and alopecia areata is possibly illustrated by a patient who was brought to me by Dr. Bright, of Forest Hill. This patient, a lady of 45, was rapidly losing the hair from the back of her head by the ordinary form of alopecia areata. The disease had begun at the usual place, and the patches had been from the first as smooth and glossy as possible. Recently another bald patch had commenced near the vertex, and on it the skin also was thin, pale, and smooth. Not a single scale could have been obtained from any of the areas, nor was there a broken hair to be seen. The history was, however, that Miss G—'s maidservant had been under treatment for ordinary ringworm of the nape of the neck six weeks before her mistress became the subject of alopecia.

CASE 5.—A youth named McI—, aged 18, was under my care in January, 1885, with typical patches of alopecia areata. His history was peculiar: he said that about the age of seven his hair began to fall in patches, and that from seven to nine he was almost bald. Then the hair grew again, but two years later he had a single patch of what his medical attendant said was ringworm. This was followed by baldness, but again, under the use of a lotion, he got a good head of hair, and kept it until about six months before I saw him. At the time of his visit to me he had several patches, quite round, and as large as crown-pieces.

CASE 6.—Dr. G—, an Indian surgeon, aged 46, consulted me on account of patches of alopecia on his scalp. It was well-marked: the patches were round, but small. It affected one side of his moustache also, and had indeed begun there. He believed that he had never had ringworm, but three sources of cryptogamic contagion were possible. He had been attending children with ringworm and alopecia; he had himself formerly suffered in India from Dobie's itch, and he was the subject of pityriasis versicolor on his chest.

CASE 7.—A butler, aged 35, was under my care in 1887 for alopecia patches in his beard. He told me that, when a boy, his brother suffered from ringworm, but he did not remember having himself had it.

CASE 8.—I saw a Miss T—, aged 22, in October, 1884, on account of complete alopecia of the scalp and eyebrows. It was a relapse, for I had treated her five years previously with success, and she had kept her hair for several years. There was a history of ringworm at the age of thirteen.

CASE 9.—A lady named C—, aged 26, consulted me on July 6, 1887, on account of a single patch of alopecia areata on the left side of her head. It had been present four months. I found on inquiry that I had myself treated her brother for ringworm twenty years before. The two were then children together, and she was exposed to the risk of contagion. Her brother had had his ringworm two years before I saw it. It was not known that his sister ever caught it. In this case under treatment, in the course of three or four months the hair grew quite well. A year later, however, I saw Miss C— again, on account of new patches on other parts of the scalp.

CASE 10.—A man named L—, aged 50, consulted me on account of alopecia patches on his chin and scalp, which had been present six months. He told me that at the time the patches first showed themselves he had a niece staying in his house, whom he was accustomed to take on his knee, and who suffered from ringworm.

CASE 11.—Mr. T. A—, aged 59, who consulted me on account of an urticarious eczema, was the subject also of alopecia areata. He had suffered from the latter for seven years, and had been under much treatment with only partial and temporary results. He still had large bald patches on the scalp, and his eyebrows and whiskers were in part destroyed. He well remembered that at about the age of eight he had

been blistered repeatedly for ringworm. Thus the interval in his case between the two maladies would be more than forty years.

CASE 12.—A young man who consulted me for alopecia entirely denied all history of ringworm. He went home, and on the following morning I had a note from an elder brother, from which the following is a quotation :—"I beg to inform you that at the age of four years, I, the eldest brother, suffered from a ringworm on the head, acquired we do not know how, and that by infection or contagion from me, our mother subsequently had one on the forehead. Our mother has occasionally of late suffered from erysipelas of the face."

CASE 13.—A young man, aged 23, who was sent to me by Dr. Macrae, of Westbourne Terrace, presented a somewhat peculiar form of alopecia. He was almost entirely bald, but his scalp was rough, and on many parts coarse hairs were presenting themselves in tufts, two or three together. Some of the hairs were white; the scalp looked almost as if it were in the position of an extensive thin scar. There was little or no scurfiness, and the sides of his head were less severely affected than the top. The history given was that in childhood he had had a beautiful head of hair. I thought it most probable that he had suffered from ringworm which had been attended by a severe condition of kerion.

CASE 14.—Mrs. L.—, of Stafford, aged 25, presented herself with patches so large that they involved almost the whole of the scalp; her eyelashes and eyebrows were also falling. She was in very good health, and stated that the present attack had commenced when she was pregnant, two years ago. Two years before her marriage, however—that is almost five years ago—she had a single small patch on the occiput, but got it well under treatment. She knew that in their childhood her brothers had suffered from ringworm, but she believed that she herself had escaped.

CASE 15.—Mrs. E.—, aged 41, mother of a large family, presented herself in 1881 with a large alopecia patch on the right side of the vertex. She said that it had begun four months previously, and that she had never had it before, and that she had never had ringworm. On her second visit to me, she stated that she had made inquiries at home, and had ascertained that when a child she *did* suffer from a ringworm on one temple. I treated this case with chrysophanic acid, and it was soon cured. Mrs. E. remained quite well for seven years, but in May, 1888, she came to me again with a relapse. She then had a patch of alopecia on the opposite side of the head to the former one. It was now, she said, exactly where her original ringworm patch had been. She was in excellent health, and the mother of eleven children. On October 24th, 1888, the hair had begun to grow on the patch she came for in May, but another bald place had come.

CASE 16.—My creed has occasionally received confirmation by the occurrence of two examples of alopecia after ringworm in the same family. On December 8, 1890, a Mrs. G.— brought me one of her

boys, a lad of eleven, with large smooth patches of alopecia; they had been present about four months. "Has he ever had ringworm?" I asked. "Yes, about five years ago." "Had any of his brothers or sisters ringworm at the same time?" "Yes, his next brother had it." "Has he got any bald patches?" "Yes, he is just beginning in patches like those on this boy."

CASE 17.—A gentleman aged 18 came under observation when the subject of complete alopecia of his scalp. He was quite bald, wearing a wig. His eyebrows and eyelashes were falling, but he still kept his moustache. He told me that at the age of 12 he had been kept at home for a year on account of what was called ringworm. The microscope was used by an experienced surgeon, and the fungus was recognised. He had been well for only about a year when the alopecia set in, the hair beginning to fall and to leave smooth bald patches.

CASE 18.—A clergyman named G—, aged 25, consulted me on account of very extensive alopecia of the scalp in June, 1886. He had worn a wig for seven years, and had perseveringly tried a great deal of treatment by iodine, &c. His scalp was not wholly bald, but he kept the small tufts that remained closely cut. He had formerly lost his eyelashes, eyebrows, and the axillary and pubic hair. On some of these parts it had to some extent grown again. He knew of no history of ringworm, but the alopecia had begun, just as usual, by a single patch on the scalp at the age of 15.

CASE 19.—I had occasion to see, with Mr. George Mackenzie, in December, 1888, a gentleman who was suffering from abscesses in connection with an attack of erysipelas of his leg. I found that he was quite destitute of hair (on the head and whole body), and he told me that he had consulted me about it when the alopecia was beginning. He told me that he had subsequently been under the care of many specialists, but had got no benefit; the alopecia had rapidly spread, and had denuded him of every hair on his body, including the eyebrows and eyelashes. At the time that he first consulted me (as I found, on referring to my notes) he was thirty-nine years of age, and had the bald patches on his occiput and over his ears. I then saw him on only one occasion (April 6, 1882). When I saw him on the second occasion (in 1888) he had for long abandoned himself to his lot, and despaired of any cure. There were a few straggling hairs on his cheeks and chin, and a little tuft of scalp-hair in front and above the right ear. This latter tuft was in itself sufficient to indicate that the disease had been serpiginous and not diffuse, for it was abruptly margined with acute angles. There was not the slightest evidence as to any kind of causation in this instance; the patient was a married gentleman in high position in society, of temperate habits, and in excellent health. He assured me that the time his hair began to fall he was not suffering from headaches, debility, or any disturbance of his health which he could appreciate. It was not known that he had ever been exposed to the contagion of either ringworm or

alopecia. It will be seen that the commencement of the disease, as is so common, on the back of the head, was suggestive of contagion from the chair. It may be added as curiously suggestive, but perhaps of no importance, that it was thought that some of the hairs had grown afresh during his severe illness; he had been five weeks in bed.

For other cases in which there was a clear history of antecedent ringworm the reader is referred to Nos. 25, 26, 27, 28, 33, 34, 35.

*Some Cases illustrating Success in Treatment.*

CASE 20.—Miss P—, aged 53, was under my care for a number of almost symmetrical patches of alopecia areata, which had been present for a year or more, and were advancing. Her hair was rapidly thinning over the entire scalp, and the margins of the patches were not so well limited as usual. She was the subject of attacks of flushing of the scalp and head, possibly in connection with her period of life. She suffered also from rheumatic gout. My notes do not record any previous ringworm. She used during four months a chrysophanic acid ointment (ten grains to the ounce) every other day. She also took a mixture which contained arsenic and nux vomica. At the end of the four months, hair had grown on all the patches. When I saw her one year later, she described her head of hair as being “as good as when I was a young woman.” In the first instance it had grown white, whilst latterly it had become dark. The cure was perfect. Miss P.’s general health had also much benefited, though she still suffered from gout.

CASE 21.—I attended a Miss B— for alopecia. On May 9, 1884, four years after the treatment and cure, I accidentally heard she remained quite well.

CASE 22.—Mr. B— has been several years under my observation on account of neurasthenia, &c. He had a single large patch of alopecia on his occiput, which was as big as an outstretched hand. I persuaded him to persevere with chrysophanic acid for more than a year. The hair at length grew well, and as I have since seen him repeatedly, I can testify that he has remained for three years, at least, without any relapse.

CASE 23.—Miss B—, of Salisbury, was under my care in 1883, for patches of ordinary alopecia. Her hair grew again well, under treatment by chrysophanic acid; and three years later I had the pleasure of learning that she had had no relapse.

CASE 24.—Miss T—, a lady of 34, who, so far as she knew, had never been exposed to the contagion of ringworm, came under my care when perfectly bald from alopecia. She had not a single hair on her head, only here and there a little soft down. She said that the hair had been coming out for nearly two years, but her complete baldness had only

been for six months. She had been under the care of several specialists. She was tall and thin, and had never been strong, but was not specially out of health; her circulation was, however, very feeble, and she complained that her head was easily tired. Her eyebrows were falling on both sides, and the eyelashes on the right side. She thought that there had never been the slightest attempt at re-growth of hair on any part where it had fallen. I prescribed, as usual, chrysophanic ointment, and gave her a mixture containing tincture of steel in full doses. I did not see her again for six months. On January 4, 1881, she came to me with the hair fairly well grown over almost the whole scalp; in some parts, however, there was still little more than down. She had used the ointment continuously and freely. Her eyebrows were growing again, but were white. I must not omit to mention that her right eyelashes were growing again, although, of course, she had not been able to use the ointment on the edges of the lids beyond the very slightest application. I saw this lady again in August, 1881; her hair had then grown well over the whole scalp, with the exception that on a single central patch, the size of a crown-piece, the hairs were still thin and short. The hair was thick and strong; her eyebrows and eyelashes had been reproduced in perfection. She was in much better health, and was still taking her medicine under the impression that she could not do without it. She had for some time disused her ointment, considering her cure complete. One year after the last note, Miss T—— came to me again with a relapse of her alopecia. The patches were again becoming bald, just as they had done in the first instance. They were as yet small, but they affected different parts, and had even attacked one eyebrow. Miss T—— said that she had never left off her medicine, though she had, of course, for long disused her ointment. I am sorry that my notes do not enable me to carry this case any further; I believe, however, that under the systematic resumption of the ointment the patient again recovered her hair. As regards the growth of the hair on the eyelashes, to which the ointment had never been systematically applied, it must be noticed that the patient said she could never use it even to her eyebrows much, on account of its causing swelling of the eyelids. Thus it is really by no means impossible that the congestion which chrysophanic acid constantly causes did extend in some degree to parts which it did not actually touch. It is quite possible that it acts as an irritant rather than as a parasiticide.

For other facts which illustrate the results of treatment the reader may refer to Cases 27, 28, 29, 33. I may state that my treatment is very monotonous and almost always consists in the persevering use of chrysophanic acid ointment, the strength of which is raised according to the patient's susceptibilities.

*Some Cases in which more than one member of the same family suffered.*

CASE 25.—Lady B—— brought me her two children, a boy and a girl, both of whom had patches which were perfectly smooth, shining, and could not be distinguished from common alopecia. Dr. Hancocke Wathen, of Clifton, who sent me the case, told me that exactly a year ago he had cured the children, by the chrysophanic acid ointment, of common ringworm. The hair had grown again quite well, and then, after an interval, had begun to fall, leaving perfectly smooth alopecia patches as described.

CASE 26.—The cases of two boys named C—— are of some interest. The elder of these, aged 13, was brought to me with a most characteristic patch of alopecia, about the size of a shilling; the scalp was thinned and perfectly smooth. I could find no trace of fungus. A month later he had two other small patches of precisely the same character, and a month later still a younger brother, aged 9, was brought to me with a patch of similar character. There was no history of these children having had ringworm previously. But it was known that one of the servants in the house had been under treatment about six months ago for that disease. In both the boys, however, the patches displayed from the first, and retained throughout, the characters of alopecia, and not those of ringworm. There is a feature which is very characteristic of alopecia, and which readily distinguishes it from ringworm, which has, I think, not been sufficiently noted, and that is the remarkable thinning of the scalp which results from the falling out of the hairs. In this instance the children's nurse, who was an intelligent woman, remarked to me, "You can find the patches better by feeling for them than looking, for there is a dent in the skin." This was perfectly true, for the children having a thick crop of stout hair, it was very easy by the finger to detect the depressions caused by falling of the hairs.

CASE 27.—A lady named Y——, aged 52, came to me in July of 1887, with almost complete baldness. She said that she had had an excellent head of hair until four months ago, when it began to fall in round patches on the back of the head. These had spread very rapidly, and already on some parts whitish downy hair was beginning to grow again. Mrs. Y—— told me, in answer to inquiries, that she had had ringworm when a child, and that her brothers and sisters had it at the same time. "It was in the village." Her father cured it, she said, by the use of an ointment which was employed for the scab in sheep. She said that they all got well much quicker than their neighbours' children who were under a doctor. A period of forty years had intervened between the occurrence of the ringworm and the appearance of the alopecia. The interest of Mrs. Y——'s case does not consist solely in its being an instance of ringworm in early life preceding alopecia in an adult. Another point of still greater importance is the fact that it had apparently been contagious. She brought with her her daughter, a young lady of twenty-one, in ex-

cellent health, in whom alopecia areata was just beginning. The patches were small but very characteristic, and after careful examination we could detect no fungus. There were no broken hairs upon them. The patches in the daughter had only been noticed a few days, and certainly had not developed until nearly four months after her mother's. It was known that she had used her mother's combs and brushes. The mother was almost bald. For both an ointment containing chrysophanic acid was ordered. I only saw them once or twice; but about a year later the mother brought to me another patient, and, with many expressions of gratitude, showed me that she had again grown a good head of hair. Her daughter also was, she said, quite well.

CASE 28.—Miss G——, aged 22, was the subject of complete alopecia of the scalp. The history given to me was, that at the age of three she had some bald patches, and that her brother and sister caught it from her. The brother got well under treatment by blistering, but the sister is still liable to have bald patches recur, which are always cured by blistering. In Miss G—— herself the alopecia had been frequently recurrent. She had formerly been under the care of the late Mr. Startin, and had always found that his blistering restored the hair. More recently she had been under Sir Erasmus Wilson. About a year before I saw her, the hair, which had been growing fairly well, suddenly fell off again; and when she came to me, with the exception of a single tuft the size of a fourpenny-bit, she was absolutely bald. I was told that even in childhood, although the malady was distinctly contagious, it had never been called ringworm, and that the patches had always been quite smooth and shiny. Miss G—— was in good health, and had never suffered from headaches or from any material illness. Six months subsequent to the above note the hair on the scalp was growing again, but the eyebrows were falling out. This case seems to be a good example of a form of ringworm which from the beginning had all the features of alopecia, and which was subsequently, like alopecia, protracted into adult life, and attended by relapses.

CASE 29.—Mr. McB——, a thin, slender man, aged 36, was under my care on account of alopecia, from which he had suffered for many years. He knew of no history of ringworm in his family; but a point of considerable interest to me was that I had attended an elder brother of his on account of alopecia areata. One of the brothers resided in Yorkshire, and the other had lived in Australia. They were nearly of an age, and as they had both developed, whilst in perfectly good health, this unusual form of disease, it seems to me a plausible supposition that they both had the seeds sown in boyhood by ringworm. The history of the case of my present patient was that his first patch occurred on the occiput, at a time when he was living in the Australian bush three years ago. He lost all his scalp-hair, eyebrows, and eyelashes, and for eighteen months had been under the necessity of wearing a wig. Finally, under the treatment of a quack, who used strong local applications, his hair grew again perfectly; that on his scalp was strong, but his beard and eyebrows were

always weak. He kept his hair for about a year, and when I saw him had been suffering for about six months from a relapse. His patches were as round and smooth as I ever saw them; thus the conditions of the relapse were exactly like those of a *de novo* case. He was in excellent health.

### *Alopecia after Fevers.*

It would be of interest to note whether those who have suffered loss of hair as a sequel to fever are liable in after life to any peculiar forms of alopecia. The falling of the hair after fever is, I believe, always general, and not in patches; and when once it grows again, it usually, I think, grows strongly and remains vigorous. I was once myself quite bald, when a student, after an attack of typhus fever, and the patient from whom I was supposed to have contracted it, a young Irishman, became quite bald also. We both of us grew our hair again perfectly well, and retained it without any relapse. One of the last cases (Case 30) in which I had the pleasure of meeting the late Sir William Gull in consultation, was that of a gentleman aged 45, in whom alopecia areata, which had begun in a single round patch of a quite definite character, ultimately spread over the whole scalp, took away his eyelashes and eyebrows, and, I believe, every hair of his body. The interesting point in this gentleman's history was that he had, many years before, lost his hair after typhoid fever. So far as I know, in this case treatment was without result. The patient had several children, but there was no history of ringworm in his family, nor any known exposure to its contagion. He was in good health at the time. Through my friend Dr. Herman Weber I have obtained recent information as to this patient's condition (I have not myself seen him for several years). He has, since the failure of all measures that I could suggest, been under treatment in Paris, but still without success, and at present he has only a little thin colourless down on the back of his head. It may be reasonably doubted whether the after-fever loss of hair had anything whatever to do with the subsequent alopecia areata.

Case 32 is one in which the loss of hair was supposed to have been caused by fever.

*Cases in which the Loss of Hair became general.*

CASE 31.—An example of the almost universal loss of hair, and of its growing again and falling again, was afforded in the person of a young woman who was under care at the Hospital for Skin Diseases, some years ago. Fanny W——, aged 25, gave the history that when she was twelve years old her hair began to fall in patches, and that she was soon quite bald. In the course of about three months she had lost not only all her scalp-hair, but her eyebrows and eyelashes, and in fact every hair that she had. None of her brothers, or sisters, so far as she knew, had suffered from it or from ringworm. She was under treatment for three or four years, and then desisted: it had several times grown again a little, and then fallen off. After two years without any treatment it began to grow again spontaneously, and grew fast. Her eyebrows were at first white, but subsequently regained their colour. During the next seven years she retained a good head of hair, but when she came under my observation at the age of 25, it seemed that the hair was again about to fall, all over her scalp. It was thin on all parts of the head, but there were many patches, some ill-margined, but others quite round.

CASE 32.—Another example of complete alopecia, occurring under circumstances very similar to the preceding case, occurred in the person of a married woman, aged 26, who was under my observation in May, 1862 (Rosiana B——). She stated that in childhood, after fever and measles, she lost all her hair from the scalp and from her eyebrows and eyelids. Afterwards it grew repeatedly on the scalp in irregular patches, but she never had a good head of hair. The eyebrows and eyelashes never grew again, nor did the hair on the pubes, or in the axillæ. During one pregnancy her hair grew again a good deal, but fell again after delivery. When Mrs. B—— came under my observation she was quite bald, except for a few small tufts on each side of her head. She had not a single hair of eyelash or eyebrow.

CASE 33.—A patient named G——, aged 30, consulted me on January 2, 1892, on account of absolute hairlessness. He had not a hair left on his body, but on using a magnifying glass, a little down could be detected on his cheeks. The history was that about three years ago a bald patch was noticed on his scalp, and that soon afterwards another came near to it. Not long afterwards, he noticed that his moustache was falling, and within a short time he had become quite bald, and had lost his eyebrows and eyelashes. He stated that the falling of the hair from his pubes, axillæ, and body generally, was extremely rapid, and that within a few months from the commencement of the malady he was quite hairless. From that time forwards no hair had grown, although he had had a good deal of treatment; he was a very florid man in perfect health. The history as regards ringworm was that his sisters had had it in childhood, and that he himself had had one or two patches, which he believed he caught from them at the age of 14. It did not appear that he had suffered at all severely. He was married, and had a child,

aged seven ; neither his wife nor child had suffered. Just before coming to me, Mr. G—— had been to the special department of one of our large hospitals, and he narrated his experience as follows:—"They wanted to inject something called pilocarpine under the skin, but from the conversation I overheard I judged that it was an experiment, so did not go again." My own treatment consisted in the prescription of the usual chrysophanic ointment, and after six months' use of it the hair was growing over the whole scalp, whiskers, and moustache.

CASE 34.—A young lady, Miss Alice T——, aged 22, was sent to me by Dr. C. E. Smith, of Manchester, in a condition of almost universal alopecia. She had lost her scalp- and body-hair, eyelashes, and eyebrows, but the latter had grown again a little. The history was that the hair had fallen in patches at the age of 16, and that it had from time to time grown again and again fallen off. There was, however, the important preliminary history that when at school, at the age of 13, she had suffered from ringworm. She had passed through a severe attack of typhoid fever, but it happened that this was one year after the beginning of the alopecia.

CASE 35.—Dr. Corbet Fletcher, in the Camden Road, sent to me a man who had for four years suffered from alopecia, and in whom it had become absolutely universal. He was a brass-turner, aged 33, married, and in excellent health. None of his children had lost their hair. As to ringworm, he did not consider that he had ever had it, but he remembered hearing something about it in his family when a boy. In him there was the usual history that the disease had commenced by bald patches on the scalp, and had very rapidly spread over the rest of the surface.

CASE 36.—Dr. Hough, of Derby, sent me some particulars as to a girl under his care, who had become almost hairless, and in whom all treatment had failed. He had elicited no history of ringworm.

CASE 37.—Mr. F. C. Smith, of Cheltenham, sent me some facts as to a case in which a patient lost hair from all parts of his body. It had begun as an ordinary form of alopecia in patches on the scalp, and had been three or four years in progress. All treatment had failed to stop the falling of the hair, and that of the eyebrows, beard, moustache, and all parts had been lost. Mr. Smith's patient was a man, by trade a farrier, and one in whom, therefore, it is very possible that contagion from an animal might have occurred.

CASE 38.—A gentleman named G——, who wrote to me from Derby, described a condition of absolute hairlessness, which had existed for three years. He said that he was in perfect health at the time that the hair began to fall, and that within three months he had lost every hair of his body. After long perseverance in a variety of treatment he had succeeded only in getting a very few fine hairs on his head and face. His hair had originally, he said, been very strong and plentiful. No facts were given me as to ringworm.

CASE 39.—Dr. Wales, of Belfast, consulted me about a lady who had lost all her hair. She was about forty years of age; the hair had sometimes grown again, and then again fallen. The point of interest in the case was that she was the subject of intermittent glycosuria.

#### CONCLUDING REMARKS.

It will be seen that amongst the cases which I have related there are many in which the evidence was quite clear that ringworm had preceded the alopecia. There are also some in which no proof of such connection could be produced. There are several in which two members of the same family, who had suffered at the same time from ringworm, became subsequently the subjects of alopecia. In several instances the history of the original attack of ringworm was, in the first instance, denied by the patient, having been either not known or forgotten, but was subsequently supplied. The cases are a fair specimen of my personal experience during the last few years in reference to the disease in question, and their results will, I suspect, differ only from those of other observers in that, being specially interested in the point, I have been more patient than usual in seeking for the history of ringworm. Much patience is indeed necessary on this point, for I have found that almost invariably the first answer to the question, "Have you ever had ringworm when a child?" is in a strong negative. Some patients have quite forgotten it; some never knew what the disease was; some doubted the diagnosis; and one and all are very willing, if they can, to ignore the fact. Inquiries on this head must be expected to give negative results in hospital practice far more frequently than amongst private patients. The latter are more intelligent as to their antecedents, and can usually inquire at home as to what happened in their youth, with much better hope of success. I freely admit that in a very considerable number of cases, even after painstaking inquiry, no history of antecedent ringworm is forthcoming. These cases, however, do not shake my belief in the creed that alopecia areata is a disease in connection with cryptogamic growth. I suspect that some of them are examples of direct contagion from alopecia itself; others of contagion to the

heads of adults from ringworm in children; and, lastly, others of contagion from pityriasis versicolor. Concerning the latter malady, I have no doubt that it is transmutable with ringworm. My theory respecting alopecia is that it is due to some form of cryptogamic life, which develops deeply in the hair follicle, and does not grow in the hairs themselves. I admit that this cryptogam has not yet been satisfactorily identified by the microscope, and that in the majority of cases the most careful examination will fail to give any indication of its presence. Alopecia areata is, however, a disease of such definite features, and of such remarkable sameness in its clinical history in different cases, that it is extremely difficult to entertain the belief that it depends on one cause in one case and upon a totally different one in another. I cannot but think that its cases ought all to be placed in one group, and since the evidence is so strong that some of them depend on antecedent ringworm or upon direct contagion, I cannot escape the conviction that they all do so.

There are certain other facts which favour the belief just expressed. Thus, although alopecia but rarely exhibits contagious properties, it sometimes does so. Many authors have recorded instances in which it affected several members of the same family, and more than one series of facts are on record in which it prevailed as a household epidemic.\*

\* By far the best example of epidemic alopecia with which I am acquainted was recorded in the *Boston Medical and Surgical Journal*, May, 1892. I am indebted to Dr. Richmond Leigh for a detailed abstract of this important paper. It occurred in an orphan asylum for girls, and no fewer than sixty-one out of sixty-nine suffered. The first case occurred in January, the second in March, and between the latter date and June 1st the total of sixty-one had been completed. The matron and four older girls who acted as her assistants escaped. Dr. Bowen and Dr. J. C. White, both of Boston, and distinguished dermatologists, saw the cases, and both agreed that their general features were indistinguishable from those of alopecia areata, and both failed, on microscopic examination, to detect the presence of any cryptogam. The hair-bulbs were wasted, as in alopecia. The bald patches are stated to have been smaller and more numerous. No preceding stage in the least resembling ringworm had been observed in any of the cases. Most of the cases were getting well in the course of a few months, and it was not thought that the cure was due to the use of any particular remedy. On this point, however, there is much room for fallacy.

The entire absence of any form of ill-health in the subjects of alopecia areata induces me to put wholly aside any inquiry on that score. We may, I think, entertain absolute incredulity as to what is called the neurotic form of this disease. It attacks young people more frequently than others, and they are usually those in whom neither headache nor any species of neurotic disturbance had been observed. It does not appear to me to be worth while in such a malady to ask an adult patient as to overwork, mental worry, and the like. Such influences may be found, if sought for, in the majority of those who consult us, and I feel very certain that when they chance to be coincident with alopecia they do not stand to it in the relation of cause.

The mode in which alopecia develops, the frequent, or indeed usual, absence of bi-lateral symmetry, and of any definite uni-lateral asymmetry, the rounded form of its patches, and their tendency to enlarge serpiginously, are also, I think, conclusive evidence as to its not being of neurotic origin. We know of no neurotic malady which has round patches that spread at their edges.

Lastly, I may allege that the modes of cure in alopecia areata by chrysophanic acid, creosote, blistering, &c., are all in favour of the belief that it is a disease of local origin. So also the facts that it always begins as a single patch, and, when it becomes general, spreads by the development of other patches from the parent as a centre, favour the belief in its cryptogamic nature. The facts as regards the occasional regrowth of hair, and, after an interval, its falling off again, are very curious. They are not susceptible of satis-

Whatever opinion we may incline to entertain as to the name which we should apply to the disease in this very remarkable outbreak, it appears to prove, beyond dispute, that there may occur a form of alopecia in patches which is actively contagious, and yet is unattended by any fungus which the most modern methods of research can demonstrate. The narrative may be placed side by side with those respecting certain other maladies, not usually virulently contagious, but which may by a sort of accident become so. I allude to epidemics, of pemphigoid porrigo, such as those described in ARCHIVES, Vol. III. p. 206, to those of puerperal fever, as related by the late Mr. Storrs, of Doncaster, and to those of epidemic eczema in workhouses, which have recently claimed much notice in my pages.

factory explanation on any theory that I am acquainted with, but they fit more nearly with some facts that have been established as regards cryptogamic life than with any other hypothesis.

*Summary.*

I may venture to offer the following conclusions as a summary of my present belief in reference to alopecia areata :—

1st. It is probable that all the cases which are well characterised, by abruptly rounded and quite smooth patches, are of one and the same nature as regards causation (possibly there is some slight exception to this in reference to syphilis).

2nd. It is probable that all cases of well-characterised alopecia areata are in some connection, remote or direct, with the presence of a cryptogam.

3rd. Many cases, probably the majority, occur in patients who have, at some former period, themselves suffered from ringworm.

4th. A few cases occur to those who have never shown signs of ringworm, but who have, at some former period, been exposed to its contagion. Some cases occur to adults as the direct result of ringworm-contagion from children.

5th. In a few cases it is possible that pityriasis versicolor, on the chest of an adult, may be the cause of alopecia areata on the scalp.

6th. There are a few cases in which ringworm assumes, from the first, the features of alopecia areata. These may occur both in children and adults.

7th. Lastly, the explanation of the frequency with which alopecia areata begins on the back of the head is probably that it is caught by contagion from the backs of chairs and cushions, &c.

## PLATE XCII.

### A SHORT-LIMBED POLYDACTYLOUS DWARF.

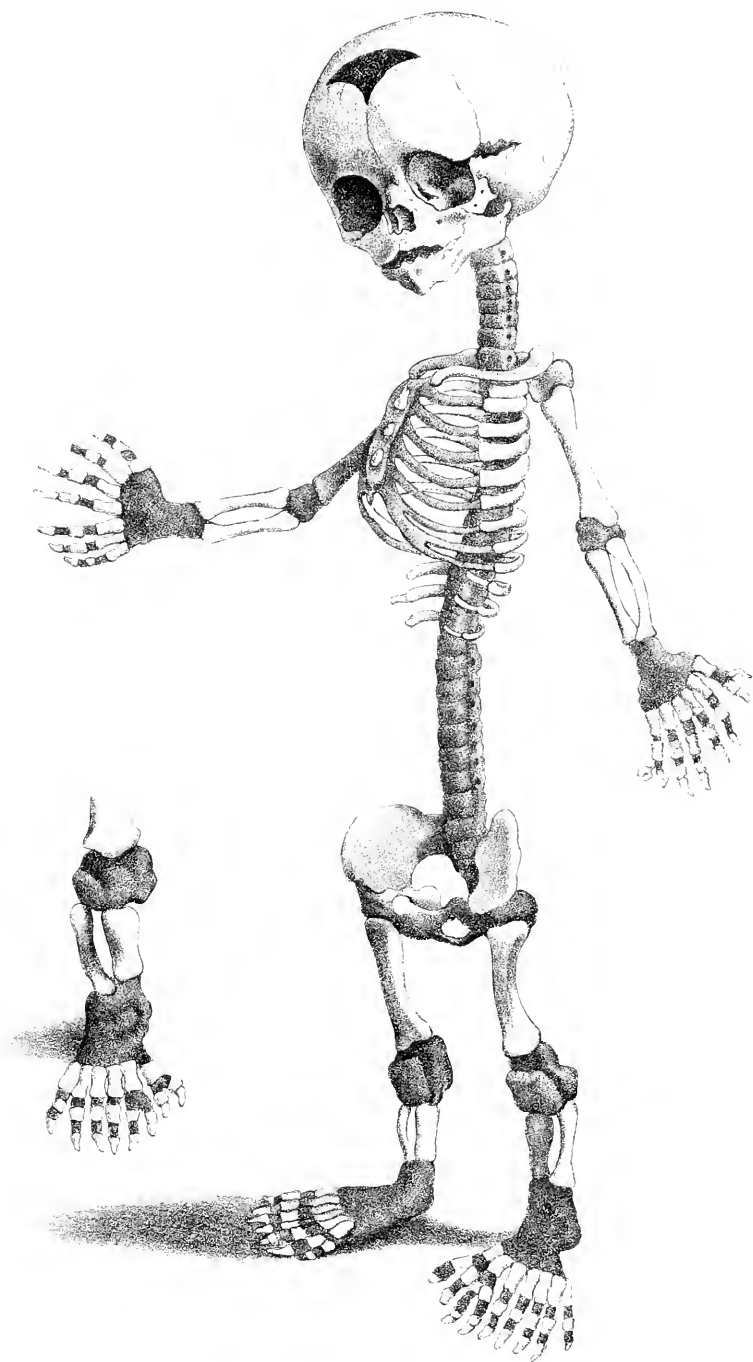
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THIS quaint figure is copied from Theodore Kerckring's '*Spicilegium Anatomicum*,' published in Amsterdam in 1670. The description states that the body was that of an infant found drowned in the river on Oct. 16, 1668. It was dissected by the renowned Ruysch. A detailed description of the skeleton is given. My reason for now reproducing the Plate is that it offers an important item of evidence in reference to the development of short-limbed dwarfs. Although we must not place too much reliance on the accuracy of the draughtsman, since he has figured some superfluous lumbar vertebræ, yet there can be no doubt that the limbs are much too short for the trunk and head. This remark especially applies to the lower limbs and pelvis. These are exactly like those of the Norwich dwarf, and of the skeleton in the Heidelberg Museum which I described in a recent number of the '*Archives*.' The point of extreme interest in the present case is that this dwarfing of the limbs is associated with polydactylism. Both the hands have seven digits. The right foot has eight and the left nine. The conditions are not exactly symmetrical, since in some instances a metacarpal or metatarsal bone is wanting; or, to put it otherwise, two are welded together. It will be seen that the upper extremities are so short that the tips of the digits will only just touch the iliac crests.

This occurrence of short limbs with polydactylism seems to prove conclusively that the condition may be due to a modification of development of a totally different nature from rickets. It is probable that the infant was not at full term. Amongst the points which the author has noticed in his description are—that the fontanelle was double its usual size; that the orbits were somewhat deformed; that the two halves of the lower jaw were already united; and that the ribs were short and badly formed.

PLATE XCII. (*continued*).

He also, of course, draws attention to the shortness of the limbs, the stoutness of the long bones, and the supernumerary digits. I find no statement that the skeleton was deposited in any museum, but it is very possible that it is still in existence in Amsterdam, and if so, it is very desirable that it should be more exactly described.





## CONGENITAL DEFECTS AND INHERITED PROCLIVITIES.

### *Various defects of development in the same subject.*

ALL facts bearing upon the combination of defects in development are of importance. I have just seen a boy of nine, upon whom, when he was an infant, I had to operate for hypospadias with pin-hole orifice. The glans penis is bent downwards, and the penis itself very small. This boy has since been the subject of what may be called an incomplete descent of the testicles. Although he is now nine, the scrotum is usually empty: the testes can be drawn down to the bottom of it with the greatest ease, but they never remain long there; in order to keep them down he has for some years, on the advice of another surgeon, been wearing a double truss. This boy has peculiarities in the formation of his head. The anterior fontanelle was very long in closing; his forehead is rounded and very large, and a deep transverse furrow crosses the skull almost from ear to ear. His lower jaw has not grown well—it is distinctly too small for the rest of his head, and his front teeth are much displaced by crowding. His incisor teeth in both jaws are perfect in formation, but in both the canine shows a curious notch.

### *Defects in the Ulnar Digits—Inheritance in three generations.*

Dr. Potter, of the Kensington Infirmary, was good enough to show me an old woman, named Elizabeth Collins, in whom deformity of the hands by suppression, &c., was distinctly a matter of inheritance. She knew of its occurrence in at least three generations, her mother and her mother's father having

had hands, as she believed, much like her own ; one of her sisters also (one of seven) had deformed hands.

In her *right hand* there was but little defect visible ; she had the normal number of digits, and none of them were much dwarfed. That there was, however, a tendency towards the condition presented by the left hand was clear, for the middle digit was smaller and shorter than either the index or ring, and both the ring and little finger had their terminal phalanx flexed.

In *both hands* the thumb and index finger were normal, the three ulnar fingers alone being deformed.

*The left hand.* In this hand the second and terminal phalanges of the ring finger were duplicated, exactly as if there had been bifurcation of the first. These twin digits were of almost equal size, and firmly united by a fleshy web ; on each there was a good nail. The middle finger was small, and shorter than the index. The bifurcated finger was also shorter than natural. The little finger was of normal size, but showed an exceedingly small nail, and was crippled by flexion of the second phalanx on the first.

It will be seen that this case bears some resemblance to that of the man whose hands I shall next describe, in that the chief defect of development falls on the ulnar half of the hand. Neither of the patients had any defect in the feet. In the case of the woman the index and thumb had entirely escaped in both hands, but in the man they were webbed in one.

*Congenital bilateral defect, by suppression, in the development of the Ulnar Digits.*

The subject of the deformity which I am about to describe was an old man in the Kensington Infirmary. I am indebted, as in the preceding case also, to Dr. Potter, the resident physician, for an opportunity for examining him. His hands presented a very remarkable example of deformity by suppression, in association with over-growth. He was not aware of any history of similar defects in his family, but on this point it is very possible that he was not well-informed. The state of his

hands had through life precluded him from any better occupation than that of hawking in the streets. His two hands, although not exactly alike, showed a tendency to defects of the same character. In each the thumb and index-finger were of normal size, and the other three fingers were dwarfed or omitted.

In the *right* hand, five metacarpal bones could be easily recognised; but the middle finger was absent, its metacarpal bone ending just short of the knuckle. The extremity of this bone was movable, and as sharply defined as if it had been amputated just below its head. It was as large as the others (suppression of the epiphysis and digit). The little and ring fingers were united and were short. The index and thumb were also united.

*Left hand.* In this hand the middle finger was wanting, together with its metacarpal bone. The little and ring fingers were united at their base and were of large size; in each the second and third phalanges were flexed. In this hand he had only three metacarpal bones.

*Superfluous Thumb on one hand—History of the same deformity in the same hand, in a single individual, in three generations.*

Amongst the patients that Dr. Hopkins showed me at the Cleveland Street Sick Asylum was an old man with a duplicate thumb on his left hand. The superfluous digit was in front of the normal one, and was curved over its base; it was small, but complete as regards its phalanges and nail. A most interesting point in the case was that the man knew that it had occurred in three generations at least—his own father, himself, and one of his sons: it had always been on the left hand. He believed that in each generation only a single individual had displayed this malformation, and that all three had shown it in exactly the same condition. I thought that he had a little thickening on the side of the thumb of his opposite hand, and that it was broader than usual, but he himself explained this by saying that it had been injured.

*Congenital absence of the Ulna and its Digits.*

There are few surer ways of obtaining knowledge than to candidly avow ignorance, and I have repeatedly found that a statement that I had never seen an example of any given condition is an almost certain means of bringing some such to light. In a recent number of my ARCHIVES I said that I had never seen an instance of congenital absence of the ulna, and that I did not know of any recorded. I was familiar with Forster's work on malformations, and with the catalogues of most of our museums, none of which contain any reference to such. It chanced, however, that at the very time I was writing the paragraph referred to, Dr. Hogarth Pringle, of Glasgow, had under his care an example of this very rare malformation. Dr. Pringle's industry has also unearthed the record of two other cases. Suppression of the ulna and its digits, therefore, now takes its place by the side of suppression of the radius, although, for some reason as yet unexplained by teratologists, it is far more rare. Dr. Pringle's cases are the following:—

1. His own case. A woman with entire absence of ulna in both forearms, and ankylosis of the radius to the humerus at elbow. Upper extremities short and small, and two digits absent in both. It was difficult to feel certain as to which digits were represented by the three which remained, and not improbably one thumb was absent and the other dwarfed. It was clear that it was not an instance of definite suppression of the ring and little fingers. Full details will be found in Dr. Pringle's paper in the "Journal of Anatomy and Physiology," vol. xxvii.

2. A case recorded in 1696 by Göller, in which a seven months foetus was born with bilateral absence of ulna and of four fingers, only the thumb being present. In the lower extremities the fibulae were absent, and only the great toes remained.

3. An old man described by Dr. Roberts in the thirteenth volume of Transactions of the Pathological Society of Philadelphia, in whom there was absence of right ulna, and of third, fourth, and fifth digits. In the left extremity the ulna was

present, but the third and fourth digits and third metacarpal bone were wanting. In this instance two predecessors had had stiff little fingers. A sister and niece were reported to have each one hand like those of the patient, and amongst his own children, of whom there were seven, three had malformed hands like their father's.

Dr. Pringle mentions a fourth case, but in it only the middle third of the ulna was absent, its carpal extremity and its digits being perfect.

*Diffuse Ichthyosis in a case of Consanguineous Marriage :  
three children affected.*

The case which I have next to relate is an instance of the family form of ichthyosis, in which it was possible, in the first place, that it was an inheritance from eczema, and in the next that the tendency had been intensified by a consanguineous marriage. The patient was a boy of fourteen, one of a family of seven, the offspring of parents who were first cousins. No children had been lost, and the whole of the seven were in good health, and several of them remarkable for athletic vigour. Three, however, were in a mild degree ichthyotic. The family consisted of three girls and four boys, and two of the boys were twins. It was the twins and another brother who suffered from the skin-affection; all the girls had escaped. I did not see the girls, but was assured that they were well-grown, and, excepting a little chest-delicacy in one, models of health. The patient whom I saw was the worst of the three ichthyotic cases, and his condition, although definite, was by no means severe. Of the two whom I did not see one was said (by his mother) "to have no pores to his skin," and to be almost wholly incapable of perspiration; the other was described as having simply a dry, rough skin. They had suffered so slightly that their father, who was present when I took the history, said he had never known that they ailed anything. Their mother knew, however, and said that the peculiarity of the skin had in all three been recognised during the first few months of infancy.

The boy whom I saw was in every respect well developed, with the exception of his skin. The affection of the latter

consisted in general harshness and dryness, with the addition on certain parts, especially on the outside of the thighs, that the orifices of the hair-follicles were prominent, causing a permanent state of cutis anserina. The only parts of the surface which were soft and unaffected were the armpits, the bends of the elbows, and the popliteal spaces. The parts where the skin was most rough were those usually affected in psoriasis, *i.e.*, the elbows, the lines of the ulnæ, and the fronts of the knees: on the latter parts the condition was very like that of diffuse psoriasis. The face was very slightly affected, being just a little branny, but it showed a large number of little pigmented moles. The prolabia were desquamating, and were, I was told, very liable to peel and get sore in cold weather. There was a history that he had, on several occasions, had an eruption of spots, or possibly patches of eczema, superadded to his ichthyosis: but of this there was no trace when he came under my observation. The state of his skin gave him very little inconvenience.

As regards family history, I might very easily have put on record that there was none whatever, for it was only after repeated inquiries, resulting in the confident assurance that there was "no skin-disease in the family," that the father remembered that two of his own sisters had long had "gouty eczema," but "that," he added, "is only gout, you know." When we remember that these two ladies were the own sisters of the boy's father, and first cousins of his mother, I do not think the suggestion will seem without probability that the predisposition to skin-disease was intensified by the consanguineous marriage. Those, however, who hold that these marriages lead directly to degeneration of the stock cannot find any support for their views in this instance. The marriage appears to have been a very happy one, and the parents were proud of their seven children, who were, with the single exception described, all perfectly developed and perfectly intelligent.

*A case illustrating congenital and hereditary susceptibility of skin.*

In the case of a gentleman named A—— H——, a

surgeon, who had the borders of his ears eaten away by chronic chilblains, or sunblains, we had a remarkable fact in proof of family liability. He remembered that his father suffered from the same, and to such an extent that he used to wear earbags in order to protect the parts from chilling. The inheritance in such cases consists probably in a peculiarity of tissue vitality. It is possible that this may be assisted, or rather aggravated, by a peculiarity also in the vigour of circulation, permitting easily, under the influence of cold, of arterial contraction, an approach to "Raynaud's phenomena." It may be suspected, however, that susceptibility of the solid tissues has more to do with it than susceptibility of blood vessels, although the two are almost always associated. Heat as well as cold, and in many instances much more efficiently, will cause these forms of ulcerating blains. (See ARCHIVES, Vol. iii.) The phenomena of chilblains are more nearly allied to inflammation than to arterial spasm.

In the case which I have mentioned above there were some other very peculiar conditions which favoured the supposition that the patient had inherited a peculiar susceptibility to local irritations in the whole of his skin. He came to consult me, not on account of his ears, but on account of a very peculiar eruption on his legs. Of this he had had several attacks, the first having occurred ten years ago during hot weather in New Zealand, and the last during the present summer while staying at an English seaside place. On each occasion a number of erythematous blotches had appeared very suddenly on his limbs, affecting the backs of his hands and his legs especially. They had never come out quite symmetrically, but usually in groups, and sometimes only on one limb. Their onset had been so sudden on at least one occasion, and attended with so much irritation, that he thought he must have been stung. He showed me on his right leg a number of discrete spots the size of split peas, and almost black with pigmentation. They had been present for several months.

I encouraged Mr. H—— to believe that his very peculiar eruption was purely of local origin, and that it had probably

on each occasion resulted, as he had at once suspected, from the bites of insects. The condition of his ears demonstrated remarkably the susceptibility of his tissues, and very probably mosquitoes, fleas, gadflies, and the like, when they attacked him produced results far more severe than they usually do in other persons. His eruption, it should be said, had on each occasion lasted several months. There was a history both of tuberculosis and of gout in his family, but I do not know that either, or especially the latter, had much to do with his symptoms.

*Inherited liability to Raynaud's Phenomena, with great proneness to Chilblains—Gradual increase of liability to paroxysmal local Asphyxia—Acro-sphacelus with Sclerodermia—Cheeks affected.*

Mrs. B——, aged about 50, is a tall, thin woman, in very good health with the exception of what I am about to describe.

She was sent to Aix-les-Bains nine years ago for rheumatic gout in her hands, and sciatica. It was there that the state of her hands was first noticed, "the tight state of the skin." She has been a martyr to chilblains, and as long as she can remember. Almost from childhood she has noticed her fingers to die and become white. Her mother was all her life liable to dead fingers, and "never came down to breakfast without some of her fingers white and tallowy."

Mrs. B—— at present date (Oct. 6, 1892) has gangrene of the end of the left forefinger, and she tells me that she has formerly suffered from the same in several other fingers.

Her feet have suffered like the fingers. The abscesses in the tips of toes began two years ago. Electricity was used a whole winter without the slightest benefit. She wintered last year at the Canaries and was no better. Her face is board-like and much freckled, with some stigmata. Her ears have not suffered, nor the tip of nose. Her nose is much less stiff than her cheeks. She has frequent paroxysms (Raynaud's phenomena).

She easily gets diarrhœa. She tells me that whisky and water does not make her flush in any special degree, but she takes very little. Port wine suits her, but it gives her gout.

Mrs. B—— had on the whole enjoyed good health through life. She appeared very cheerful, and assured me that no mental distress or shock had preceded the development of the disease. She had no family, and had been accustomed to all the comforts of life. She was accustomed to take much horse exercise, and said that she could still manage her bridle with her left hand.

Amongst the points to be specially noted in this case are the following:—It forms one of the most definite connecting links between Raynaud's disease and diffuse sclerodermia that I have ever seen. The paroxysmal changes in the condition of the fingers has been very marked indeed. Thus her fingers may die and recover again several times in the day. When she came into my room one forefinger was quite white, while all the others were red. In the course of ten minutes, however, this finger had become red also. This tendency to paroxysmal variation of condition is the essential character of Raynaud's malady, and is much less marked in ordinary cases of sclerodermia, or may not be noticeable at all.

My object in adducing in the present series the last case is to draw attention to the fact that the liability to Raynaud's phenomena is often, indeed I believe usually, a matter of inheritance. I could cite several other cases in which a daughter presented exactly the same symptoms as her mother had previously done. In a paper on Acro-pathology which I have recently published in the *Semaine Médicale*, I have advocated the view that the phenomena in question are, to a large extent, the result of congenital organisation. As regards the coincidence of sclerodermia with Raynaud's malady, I may briefly say that although we now and then see them together, their connection is by no means essential.

## ON CERTAIN DISEASES OF THE TONGUE.

### *The Earliest Stage of Cancer of the Tongue.*

A PATIENT whose tongue I had sketched in January, 1893, as an illustration of the very earliest stage of cancer, afforded a good instance of the very insidious manner in which malignant processes sometimes originate. This man had been for some months under the observation of one of the most careful diagnosticians in London, and had been assured, only a few weeks before I saw him, that there were no indications of cancer. His tongue presented a good example of white-paint-sclerosis. He had suffered from syphilis thirty years ago, and had been in the interval an inveterate smoker. There was certainly nothing in the appearance of his tongue which, according to our old notions of diagnosis, would have raised the slightest suspicion of cancer. There was, however, a patch on the dorsum, not very far from the tip, from which the white-paint thickening had cleared away. This patch was about the size of a shilling: it was not in the least ulcerated, and was scarcely raised, but it was firm to the touch, and it presented over its whole surface a minutely granular appearance. It was like a portion of cauliflower buds on a very small scale, and flattened down. I could not feel any doubt that it was really the first stage of epithelial cancer. I was told that it had considerably increased during the last two months. On examination of the floor of his mouth I could detect, near the angle of the jaw, two slightly enlarged glands. I of course advised the immediate excision of the whole tongue.

### *The Pre-Cancerous Stage of Cancer of the Tongue.*

On the day following that on which I saw the preceding

case, another presented itself, in which the symptoms were on a yet smaller scale. They were, however, precisely similar. The little sore was on the left side of the tongue, not far in front of its base. It was not so large as a threepenny-piece, and it is an exaggeration to call it a sore, for it was detected by the eye with some difficulty. On applying the fingers to the two sides of the tongue, however, it was quite certain that whilst on the sound side the structures were soft, on the other there was a little disc of induration. About this my son, who saw the case with me, was equally assured with myself. The surface of this indurated patch was minutely granular, and the sore spot had been the seat of a pricking pain which had made the patient anxious. This sore was in exactly the same place, and in all respects exactly similar to one which I treated many years ago in the person of M. N——, himself a surgeon. In that instance we were both of us for some time very anxious about cancer. By repeated applications of the caustic acid nitrate of mercury, very liberally used, we succeeded, however, in getting rid of the growth. M. N—— lived many years afterwards, and had no further trouble with the sore. The satisfactory result of that and some other similar cases encourages me to venture upon a similar plan in this instance, and to abstain for the present, at least, from the more radical method of excision.

*Note.*—Since the above was written I have made three applications of the acid, and with the result that all induration has disappeared: and that, for the present at least, all anxiety has ceased.

*On a rare Eruption on the Tongue to which the term "Symmetrical Filmy Patches" is applicable (true psoriasis of the tongue).*

There is a condition of the tongue of which I think the term "symmetrical filmy patches" is perhaps as descriptive as any that can be suggested. It is, I believe, an example of an eruption on the tongue, and is not due to any local cause, nor in any way influenced by such. Its symmetry indicates that this is its nature, and its occurrence not infrequently in association with disease of the skin gives support to the sug-

gestion. Its recognition is of great importance, since it may easily be mistaken for a symptom of syphilis, although it has, I believe, nothing whatever to do with that disease. I am not now describing "the filmy patch" for the first time. I first noticed these patches in several cases of lichen planus, and I described it in my Lectures published in the year 1880. My friend the late Dr. Sparkes, in conjunction with Dr. Bruce, had previously described a very peculiar group of white bodies on the tongue in a case of pityriasis rubra. They were, however, on one side only, and showed as boldly defined tubercles, about the size of a split pea. This description by no means fits with the patches which I am now describing. In some cases the symmetry is not quite complete, inasmuch as the patches are larger on one side than the other; but, so far as I have seen, there is always a very definite tendency to bilateral arrangement. The patches which compose the groups are often somewhat irregular in form, and although more or less rounded, are seldom accurately so. They may vary in size from a pin's head to a split pea, or to a threepenny-piece. They are never seen in the middle line of the dorsum, but always arranged in a long streak, one on either side. Now and then there are some white patches under the tongue as well, and not unfrequently there are spots in the mucous membrane of the cheek. These patches are to be carefully discriminated from those of superficial sclerosis, so commonly seen in smokers, more especially in smokers who have previously suffered from syphilis. In the latter the patches are almost always ill-defined, and their formation is preceded by baldness from destruction of papillæ. As a rule, in the condition of sclerosis no papillæ whatever can be distinguished. In the disease which I am endeavouring to describe the papillæ are not wholly destroyed, but are glued together and covered by a thin, whitish, semi-transparent film. Through this film the fungiform papillæ are often easily seen. There is scarcely any thickening, since a partial atrophy of the papillæ makes up for the new formation on the surface.

As regards the class of patients who are liable to the filmy patches, I believe they will usually be found to be in excellent

health, and wholly unable to assign any cause for the condition of the tongue. The patches do not produce any inconvenience, and I believe that they may pass away without leaving any permanent change. I have seen them more frequently in men than in women. I possess several drawings illustrating this disease; but before referring to them I will describe a recent case in which I have recognised their presence. It was a very well-marked example of the disease.

A gentleman, aged 36, who had been married ten years, and had healthy children, sought advice on account of the condition of his tongue. He had been for some months under treatment, and had been using chromic acid. Suspicions had also been expressed that the condition was syphilitic. It was an excellent example of the filmy patches. On each side of the central line, not far from the tip, was an irregular rounded white patch, as large as a threepenny bit, and from this others extended backwards in a line on each side, midway between the middle and the edge of the organ. There were some extremely slight patches in the cheeks. The patient had never had syphilis, and he had no stopped teeth. He had never suffered from any form of skin disease. He had formerly been a smoker, but had left off three months before I saw him, and without any benefit to his tongue. He told me that the patches had come out rather quickly, and at several places at once. This was five months before I saw him. On looking carefully at the patches with a magnifying glass, the appearances suggested a thin layer of whitish size, spread over somewhat shrunken papillæ, and smoothing them down. On the most careful inquiry I could find nothing either in the patient's state of health, or in his habits as regards local irritation to explain the condition. Amongst other cases in which I have recognised this disease I may mention the following:—

A gentleman, aged 44, whose case is given on page 212 of my Lectures, had these patches in association with a copious eruption of lichen planus. Under treatment by arsenic the tongue got well before the skin, but both were in the end quite cured.

A gentleman named L——, aged 48, presented the condition

described. In addition to the symmetrical patches on the tongue, there were white-edged, map-like patches on the pouches of the cheeks. He had never had syphilis, and smoked but very little. He had no skin disease, but his nails were somewhat fluted lengthwise and rather rough at their roots. The patches had been noticed for about eighteen months when I saw him in May, 1885. I do not know anything as to the further progress of the case.

*Filmy Patches on Tongue without obvious cause, but in association with liability to Urticaria.*

A remarkable example of what I have sometimes called the filmy patches on the tongue, those which occur with lichen ruber, was brought to me by Dr. Hack Tuke, his cook being the patient. They were symmetrically placed, two on each side, about midway on the dorsum, and exactly resembled those depicted in one of my drawings. The patient believed that they had been present only a few months. She was brought to me not on account of the tongue, for indeed it had not attracted any notice, but on account of a very troublesome irritability of the skin. From this she had suffered for many years, and it appeared from the descriptions given to be a sort of urticaria. There was nothing to be seen at the time she was with me, but I was told that she was often kept awake at night by extreme itching of the whole surface, and that wheals and long streaks of redness would show themselves. I was told that the eruption was specially prone to occur round the waist where the strings of her dress pressed, which is so often the situation affected in lichen planus. The patient was a healthy-looking young woman of about five and twenty.

*Chronic Glossitis, with films chiefly on the sides of the Tongue, and possibly due to amalgam tooth-stopping.*

The condition of tongue presented by Colonel D—— was somewhat peculiar. He had no abrasions or ulcers, with one very trivial exception; but the whole border of his tongue on both sides was abnormally smooth and red, presenting

at almost regular intervals little ill-defined patches of white film. These films could not be detached; they were especially conspicuous near the tip. On its surface the tongue was clean, rather too smooth, that is the papillæ less conspicuous than normal. The tongue was not indented at its edges, but the little white films seemed to correspond with the intervals between the teeth. Similar slight films were beginning to form just inside at the corner of the mouth (smoker's patches). Colonel D—— had been under treatment by his family attendant for upwards of a year, but his tongue had been getting worse rather than better. He had been chiefly treated for dyspepsia. The problem was to find a cause for his chronic glossitis. He appeared to be in excellent health, and of late he had smoked exceedingly little. In early life he had smoked heavily. He had never had syphilis, and he scarcely ever drank effervescing drinks. His teeth were in very good condition and very carefully attended to; many of them had been stopped, some with gold and some with amalgam. He thought he had had the amalgam in some of them for upwards of twenty years. The soreness of the tongue had only come on during the last year or two, and as he assured me he did not smoke a cigar oftener than once or twice in a month, I was driven to suspect that the amalgam stopping might have something to do with the glossitis.

*Examples of Neuralgic Pain in Tongue, possibly due to Gout.*

There is a definite group of cases in which patients complain of pain on one side of the tongue, just in front of the pillar of the fauces. The part affected is only brought into view when the tongue is put out to the uttermost. In this position there exists naturally a series of vertical ridges which are larger in some persons than in others. Patients who become subject to soreness or pain in this position almost always find out these ridges, just as others discover the papillæ circumvallatæ, and in each case mistake them for the beginning of cancer. Sir James Paget has, I believe, drawn attention to the occurrence of pain in this particular part of the tongue, and has associated it with gout. It has

occurred to me to have to treat several very troublesome examples of it, and in more than one there was some definite hypertrophy of the folds in question, with appearances which made me apprehensive that cancer might really be beginning. One of my patients in this category was himself a distinguished surgeon, well cognisant with the early stages of cancer, and for upwards of three months neither he nor I could venture to feel quite certain that the condition was of no importance. There was no actual ulceration, but there was pricking pain, slight hypertrophy, and, as compared with the other side, a little induration. The pain was constant and troublesome. We made repeated applications with the caustic solution of the acid nitrate of mercury, and in the end succeeded in getting rid both of the pain and of the local changes. In this instance there was no proof of gout, but it was still very possible that a tendency to it existed.

In the case of a florid widow lady, aged about 60, whom I have seen at intervals during several years, precisely the same conditions as those just described were present, and I have adopted a similar treatment. In her, however, there is no room to doubt that a gouty tendency does exist. She has had pain in the smaller joints, and frequently passes uric acid. The pain in the tongue has often seemed to be relieved by the use of alkalies. As there has been almost from the first decided thickening and even a slight tendency to ulceration, I have not felt justified in trusting gout remedies, but have repeatedly and freely cauterised the parts. She has been on one occasion quite free from pain for a year, and then at the end of the time returned to me with the same complaint.

A third case was brought to me last year by Mr. Oliver C. Maurice, of Reading. In this case the patient was younger than any of the others, being not more than forty. The symptoms were exactly the same, a frequently recurring pricking pain in the side of the tongue, and a slight hypertrophy of the folds in question. There was, however, nothing at all definite as indicating cancerous ulceration.

I have seen a good many of these cases in which there was pain only, and no proof whatever of local change, and in most of these the patient's age and history might quite support

Sir James Paget's statement that the affection has its origin in gout. Remembering, however, the extremely insidious manner in which cancer often begins, and holding strongly the opinion that its first stage is in many instances a form of inflammatory hypertrophy, I have seldom felt able to tell the patient that it was safe to wholly disregard the symptom. Such patients are almost always at the cancerous age, and although it is right to allay their fears as much as it is possible, it is at the same time necessary that the case should be kept under observation. The pain is fortunately in most instances sufficiently definite to ensure this. As regards the precise character of the pain, it is sometimes described as a dead ache, and sometimes as the pricking of needles, and it is often attended by a bitter taste on that side of the mouth. Careful attention should, as a matter of course, be given to the state of the teeth near to the painful part of the tongue. Not only should they be examined as to any roughness which may be present, but also as to any amalgam stopping. I feel sure that such stopping not infrequently causes a bitter taste in the part of the mouth nearest to it, and believe that it not infrequently originates disease in the tongue.

A footman, aged 59, had suffered for three years from what he called a sore tongue. He had tried the patience of several surgeons before I saw him; there was nothing whatever to be seen, and yet, as he alleged, his life was made a misery to him by a constant sense of soreness in the tip of his tongue. He compared it to "a red-hot ball," to "a whitlow throbbing in the finger, as if a wasp had stung me and it was swollen up," and had other similes, all expressive of severe pain. He said that he was constantly seeking a comfortable place in his mouth for his tongue and trying to cool it. I could find nothing, excepting that the median fissure was at the top a little more marked than usual, and that the papillæ near it were pointed and red. There was no ulceration. The pain complained of had been present more or less for three years.

The patient was a healthy man, and although a butler, it was in a teetotal family, and he had never had access to wine. He had taken stout and beer regularly, but never in

excess. He had never been threatened with gout, nor was gout known to have occurred in the family.

I applied the acid nitrate of mercury very freely to the cleft in the tip of the tongue, and ordered aconite and alkalies.

In this case, as in others, the pain passed up the *left* side of the tongue.

## SYPHILIS.

No. XLV.—*A Case in which it would appear that Primary Syphilis was communicated in marriage more than two years after the original disease.*

I have recently seen a gentleman who told me that he consulted me in reference to his proposed marriage in 1890. He had had syphilis in 1888, had been treated for a year or more, and had been for nine months wholly free from symptoms and without treatment when he came to me. He assures me that I gave him full permission to marry, and as more than two years had elapsed his statement is, I have no doubt, correct. He married in October, 1890, two years and six months from the date of his chancre. On return from his honeymoon he had to consult his medical attendant on account of an abrasion on his glans. It was not, he believes, on the site of the former chancre. It was said to be nothing, and in the course of a week or two was well. His wife, however, about two months after marriage came out in an eruption which was pronounced to be syphilitic. She had conceived, but as she had complained of soreness, and as he had had an excoriation, it is more probable that she contracted primary disease than that she was infected by her foetus. She was treated for syphilis, and got rid of all symptoms for a time. The child, a girl, born at eight months, also required treatment, but is now well.

Thus it is beyond doubt that in this instance a newly married wife contracted syphilis immediately after her marriage. It is also certain that the man she had married had suffered from prolonged constitutional syphilis, the beginning of which dated back two years and a half. The probabilities

seem to be that sexual intercourse abraded the glans and that the sore thus produced proved infective to his wife. We must, however, stop short of assuming that this is proved. There is the possibility that either he or she may have acquired syphilis from some other source just before or just after marriage. There is no known probability that such was the case, but it is yet a possibility. I have seen a case in which a young married lady of good family developed a sore on her genitals, as was supposed at first, from rupture of the hymen. Enlarged glands in the groin resulted, and after a few weeks a syphilitic eruption. Her husband had no syphilis, and had never had any, and the upshot of a most searching inquiry was that the sore had been contracted by unchastity just before marriage. It is obvious that in such a case, if the husband had admitted syphilis, no matter how many years ago, that the suspicion would have attached to him. We can never be sufficiently on the alert as to such possible sources of error in reference to sexual matters, nor must the position or apparently excellent character of our patients ever be allowed to mislead us.

No. XLVI.—*Supposed transmission of Syphilis by a father who married four years after his disease—Doubts as to the Diagnosis.*

The case of Mr. R—— is one of much interest in reference to possible errors in the history of hereditary syphilis. This gentleman married, with my permission, in 1878, having had syphilis four years previously, but appearing to be in perfect health. His family medical attendant, in a country town, knew all about his syphilis. Within a year of his marriage his wife was confined. Both he and his wife had remained apparently in sound health. The child at birth appeared healthy. Six weeks after its birth I had a letter from the family medical attendant, stating that the infant had, two weeks previously, that is at one month old, lost its health and become wasted. My informant added that he had found two rather deep ulcers—one on each side of the fauces; and that after attending it three or four days it had suddenly

struck him that the case might be one of congenital syphilis, that he had given one grain of calomel four times a day, under the influence of which the ulcers had entirely disappeared, and the child's health had been almost completely restored. Thus it will be seen that the child had no rash or snuffles, and that a fortnight's treatment with calomel had sufficed to quite cure it. It was impossible, however, to reject the evidence, which seemed to imply hereditary taint, although at the same time one could not but remember that deep ulcers in the fauces are amongst the very rarest of occurrences in that disease, and, further, that it is often not very easy to inspect the fauces of a young infant without error.

I heard no more of this family for fourteen years. At the end of this time Mr. R—— called on me in much distress because another child of his had died. Two children had been born since the one whose infancy is described in the above notes, and of these one, a girl, was living, and in excellent health, having never shown a single suspicious symptom. A third child, however, born about a year ago, had wasted away, and the family surgeon had suggested that his wasting was due to syphilis. On careful inquiry I could not discover that there had been any suspicious symptoms excepting the wasting. I was told, however, that the eldest boy, now aged 14, had got deformed teeth, which had been regarded as characteristic. Mr. R—— and his wife had both of them remained in excellent health. It is to be particularly noted that Mrs. R—— had never at any time displayed any suspicious symptom. I had never seen the eldest child, and it occurred to me now to ask if it could not be brought to me, that I might see for myself whether he displayed any indications of inherited taint. He was away at school, but his father at once acceded to my wish that he should be brought up for my inspection. This was done. I found that he had his teeth rather severely defective, but the conditions were those due to stomatitis and probably mercurial, and not characteristic of syphilis. His upper central incisors were undoubtedly "notched"; but the notches were broad and due to the breaking away of craggy edges, and not to an arrest of development of the middle denticle. He was a well-grown,

very healthy-looking lad ; there was not the slightest peculiarity about the formation of his skull, nor anything in the least indicative of syphilis in his physiognomy. I examined his choroids and found no trace of disease.

It will be seen that there still remains for us, as a help in diagnosis, and a conclusive one, the possibility that this boy may yet show interstitial keratitis. If he should never do so, I may confess that I shall feel much inclined to doubt whether there has ever been syphilis in the family. It will be seen that the solution of the doubt is extremely important. If Mr. R——'s eldest boy really suffers from syphilis, then it would seem proved that a father, at the end of four years after his syphilis, and whilst himself remaining in perfect health, may be the father of a tainted child. It would prove also that the wife, who bore this child, may remain apparently in the most perfect health. Further, the facts would seem to imply, although not to prove, that in inheritance, under the conditions described, from one or both parents a tainted child might be born, destined to die of the disease, so long as sixteen years after the acquisition of the malady by the father. I am by no means prepared to deny the possibility of any of these occurrences, but they are all of them very improbable, and we ought to be very careful as to what evidence we admit in their support.

#### No. XLVII.—*Difficulties in the Diagnosis of Syphilis.*

One of the most difficult cases which I have ever had to determine whether a man had or had not had syphilis was that of Mr. P——. This gentleman, then aged 23, was brought to me by a medical friend in February, 1883 ; his limbs and trunk were covered with a dusky lichenous eruption, which had been out for one month. It was as like a syphile as possible, and Mr. P—— admitted exposure to risk on several occasions, but he had never had the slightest abrasion. Mercury had been prescribed before I saw him, and the rash was considered to be already fading. The most careful examination failed to discover anything like the remains of a chancre anywhere. He had no sore throat. I

expressed doubt as to the diagnosis, and advised the tentative disuse of specifics. This was done, and during the next fortnight the eruption faded away, with general desquamation. A year later Mr. P—— came to me, very nervous, about some falling of his hair, but he had no other symptoms of syphilis. He was liable, however, to some herpetic sores on his tongue. Ten years later he consulted me again, this time in reference to his marriage. No reminders of syphilis had occurred in the interval, and I of course told him that he might quite safely marry, although I could by no means feel sure that he had not had syphilis.

No. XLVIII.—*A Chancre which remained indurated for ten years.*

A surgeon, aged 31, consulted me about a sore, with a most extraordinary history. It was situated in the roll of the reflected prepuce, and was so hard that I took it for a recent Hunterian chancre. He assured me, however, that it had been present for ten years; it was as hard as cartilage. He admitted that it had definitely increased during the last six months. In support of his assertion that the sore was not of recent origin were the facts that he had no enlarged glands in the groins, nor any eruption or sore throat. According to his account he had never submitted himself to any systematic treatment. In the first instance the sore had been diagnosed as non-infecting; three years after its commencement he suffered from orchitis, which was painless, and which was diagnosed as syphilitic. It disappeared after very little treatment. Dr. K—— appeared to have absolutely neglected his symptoms throughout; but he did not admit that he had ever suffered from anything definite except the persistent chancre. He consulted me chiefly on account of a sore tongue. His tongue was ulcerated and showed filmy patches with much papillary overgrowth; I could not, however, feel sure that it was syphilitic. The chancre in this case was a long low roll of cartilaginous induration: it was congested but not ulcerated.

No. XLIX.—*Induration of a Chancre lasting, in spite of treatment, for two years.*

I have seen not a few cases in which indurations have persisted in the site of chancres for very long periods. The above is, however, an extreme instance of this curious phenomenon. Since writing out the case, another example, the facts respecting which are of considerable interest in more than one direction, has come under notice.

A gentleman, aged 27, was sent to me by Mr. J—— T——, of S——. The history was that he had contracted syphilis two years ago, and that in spite of much treatment the chancre had still persisted. I found a collared induration in the roll of the reflected prepuce. It was of considerable size, and as hard as cartilage. At its base was a superficial non-secreting ulcer. The patient assured me that this was his original chancre, and that, although it had varied in size and degree of hardness, it had never wholly disappeared since he first acquired it. He said that it had repeatedly healed, and that he had generally attributed the fresh ulceration to irritation during intercourse. He had abstained from intercourse entirely for nine months after the first chancre, but not so of late. During the last eighteen months he had been almost continually taking either mercury or iodide of potassium, and on several occasions had had his gums slightly sore. Whenever they were so, the mercury had been left off and the iodide substituted. The latter had always had the effect of depressing him very much.

The history as regards the early stages of this remarkable case, was that at first the sore was supposed to be "soft," but that it indurated after a month or two, and would not heal. No specific was used until it had been present nearly two months. The glands in the groin enlarged and became hard, but there was no threatening of suppuration. At no time was any definite eruption observed on the body, and although his throat was sore, his medical attendant did not consider it was characteristic. The glands in the groin subsided, and at the time that he consulted me there was nothing very definite. The patient was a man of dark complexion and

excellent health. He had lost flesh and strength considerably during the last two years, but this was probably to be attributed chiefly to the treatment, as he had taken a great deal of iodide of potassium, &c.

These cases are of great interest in reference to the pathology not only of syphilis but of other infective diseases. They have also a very important practical side. It is clearly impossible to say, in fact the probability is perhaps the other way, that chancres which have existed even for several years may not still retain some contagious elements. It would appear to be possible for these elements to remain living in the tissues in which they were first implanted long after they have died out from the system generally. By far the most important risk to be contemplated, when according to rule we permit marriage two years after syphilis, is the possibility that under the influence of renewed and repeated intercourse the original chancre may relapse. I believe that this risk is a very small one, but it is impossible to deny its reality. I have published several cases in which, under circumstances of apparent safety, chancres have returned. When they do so it is always, I think, in the site of the original sore, and this site is also almost invariably in the roll of the reflected prepuce. As regards these persisting indurations, it may be suspected that they always occur in cases in which the treatment has been inefficient, and not unfrequently in those for whom the iodide has been substituted for mercury. Clearly the measure to be carried out is a long continued or otherwise thoroughly efficient course of mercury.

#### No. L.—*Permanent cures of Tertiary Syphilis.*

I treated an officer in the army (Mr. A. H——) in 1880 for a most severe tertiary ulceration of the throat. Several cauterisations with nitric acid were required, but by their aid and local applications of iodoform, and without the use of iodides and mercury, it finally healed well. I saw him again in 1893, when he had the appearance of perfect health, and told me that during the thirteen years which had elapsed he had never ailed anything.

I also treated the brother of the above patient in 1887 for a very large ulcerated gumma on the front of one leg. It was ten years after his primary symptoms. His sores healed under mercury, iodides, and iodoform. In 1893, that is after six years, I heard that he had since the treatment had good health, but was now urgently ill with acute catarrhal pneumonia of four days' duration.

No. LI.—*Two attacks of Syphilis with an interval of nearly five years—Apparently excellent recovery from both.*

AGE.	DATE.	DETAILS.
28	1877	Had a chancre (penal), not much hardened.
29	1878	Complete secondary symptoms. Treated by mercury.
30	1879	Periostitis on one tibia. Cured by biniodide.
31	1880	Quite well.
32	1881	Quite well.
33	1882	A second chancre, well indurated and characteristic.
34	1883	An ulcerated throat and some pustules on scalp followed the chancre.
35	1884	A gumma on one leg, which ulcerated, and has left a deep scar.
36	1885	Quite well.
37	1886	.. ..
38	1887	.. ..
39	1888	.. ..
40	1889	.. ..
41	1890	.. ..
42	1891	.. ..
43	1892	In excellent health. For eight years past has taken neither mercury nor iodides.

I did not myself see this patient until 1892, when he consulted me solely on the question of marriage. The diagnosis of all the symptoms mentioned rests therefore with the patient himself and the surgical friends whom he consulted at the time. He was an intelligent and experienced surgeon. The case illustrates the occurrence of a second chancre, which, as regards induration, presented much more characteristic conditions than the first had done. It was followed by a characteristic sore throat, and that the eruption was not more plentiful may be plausibly explained by the circumstance that early treatment was adopted. The case offers also a good example of successful treatment on both occasions, although in each symptoms of the tertiary group occurred.

No. LII.—*A second hard chancre two years or more after a first—Both treated by Mercury—Some doubtful secondary symptoms after the second—Periosteal and cerebral symptoms two years after the second, with double optic Neuritis.*

AGE.	DATE.	DETAILS.
26	1886	Had a chancre, which Dr. H—— assured him was hard, and treated by a three months' course of mercury. It was long in disappearing.
27	1887	No secondary symptoms that he remembers appeared. No treatment.
28	1888	Quite free from symptoms. No treatment.
29	1889	Quite free from symptoms. No treatment.
30	1890	In the early part of year another chancre, which was again by the same surgeon diagnosed as hard, and treated by mercury. The sore did not last a month, but some eruption followed.
31	1891	He continued treatment by mercurial baths, iodides, &c., on account of some eruptions and periosteal pains.
32	1892	He came June 7th (for first time) to me with sore nose and pains in shins. Afterwards (in September) pain in occiput, drowsiness, giddiness, and double optic neuritis.

The diagnosis of the chancre in this case was by the same surgeon on both occasions. He is a well-experienced specialist, and he is reported to have expressed a very positive opinion respecting it. The sore on the first occasion lasted about two months ; in the second, only one.

No. LIII.—*Syphilis from inoculation without primary sore.*

I have seen several cases in medical men who have received slight injuries to their hands, and in whom constitutional phenomena of syphilis followed without the occurrence of any primary sore. In one of these, a little brown stain was all that was ever noticed as marking the site of the part which had been pricked. It was so insignificant that it would never have been noticed had not constitutional symptoms followed. I have quite recently seen another case, in which the absence of local symptoms was yet more absolute.

A medical man of middle age, who had never before had syphilis, attended a woman in her confinement who had on her vulva numerous condylomata. The perinæum being torn, he was under the necessity of using stitches, and it unfortunately happened that he pricked his hand. The prick was a quite definite one and drew blood, and knowing as he did that the woman had syphilis, he was from the first very anxious about himself. On the same day that the accident occurred he consulted his partner as to whether anything could be done to prevent infection. As there was no abrasion, it was decided to be useless to attempt any cauterisation. No local changes whatever occurred. The accident occurred on December 16th, and about the middle of February some spots were noticed for the first time on the trunk. I was consulted on March 7th, and at that time there was a tolerably plentiful papulo-sealy eruption on the chest, abdomen, and fronts of arms, about the nature of which I could not feel any doubt. The condition of the tonsils was suspicious, but not quite definite. The site of the prick in the hand could not be identified, and there was no swelling in the axilla. I was allowed to make a complete examination, and could find no trace of a chancre elsewhere.

No. LIV.—*Very severe Syphilis—Primary, secondary, and tertiary stages all within a year—A former attack possible.*

A gentleman of forty, passing through London in his return to a colony, consulted me on account of a sore which he had been assured was "soft." He had contracted it on July 27th, and I saw him on August 22nd. The frænum had been destroyed by an ulcer which was now assuming induration. I told him that he undoubtedly had syphilis, and as usual prescribed mercury in the form of grey powder pills. I heard nothing more of him until nearly two years later, when his surgeon, being in London, was good enough to call to give me the sequel. It had proved a most severe attack. The sore had become phagedænic and destroyed a considerable portion of the glans, and there had followed a copious eruption of

rupia. No sooner was the rupia thought to be nearly well than ulceration occurred in his nose—periosteal gummata. Thus within a year of his contracting the disease, the vomer, the whole of the hard palate, and almost the whole alveolus on both sides of upper jaw had been lost by exfoliation. Under liberal treatment by specifics, &c., in various forms, the disease had at length been conquered, and the patient was in fair health and free from symptoms. He was, however, severely scarred, and had an enormous hole in his palate which exposed the sides of the nasal chambers.

Before we accept such a case as this as an instance of syphilis running into the stage of periosteal gummata with exfoliation, before the secondary symptoms had cleared and within a year of its acquisition, it is necessary to add the record of another fact. When he first consulted, me Mr. C—— told me that he had twelve years before had a sore which he was told was “soft,” and from which nothing had followed. Thus it was quite possible that his recent attack was a second one. The fact that his second chancre ulcerated from the first, destroyed the frænum, and finally became phagedænic after it had assumed induration, favours this view. In most cases of phagedænic chancre there is, in my experience, the history of previous syphilis, or at any rate of a previous sore. The same remark applies to the occurrence of rupia and to all forms of ulcerating secondary eruption. It is not possible in this instance to say anything with certainty as to the influence of specific remedies. Did the phagedæna and rupia occur in consequence of the mercury given, or were they rather from want of larger quantities? In an early stage, when the disease threatened unusual severity, the grey powder pill was substituted by the protiodide of mercury, and it was whilst taking the latter that the disease became yet more aggravated. Although it resisted treatment for long, yet finally specifics conquered. Very large doses of iodide of potassium were given. There can be no doubt that the patient was susceptible to the poison of syphilis in a very peculiar manner. This was proved at every stage, and the question of most importance is whether this peculiar susceptibility came from the influence of a previous attack.

## DISEASES OF THE NERVOUS SYSTEM.

### No. XLV.—*On the Early Symptoms of Tabes.*

It is often exceedingly difficult to distinguish the flying pains of tabes from those of gout: not infrequently, I believe, the two diseases co-exist; and although the diagnosis of tabes from other symptoms may be certain, the pains may still be in part due to gout, and may be curable on that hypothesis. The case of Mr. M——, a man aged 30, whom I saw in January, 1893, illustrates these statements. I had treated Mr. M—— in January, 1890, for some tertiary symptoms of syphilis. They consisted solely of sores on the tongue, and it was then eight years since the primary disease. I cured his tongue by insisting on the removal of some teeth which were stopped with black amalgam, and on his giving up smoking. The acid nitrate of mercury was also applied. When Mr. M—— came to me three years later, his tongue had for long been quite well, and he had been quite free from all symptoms of his old complaint. He came because he had been suffering from pains in his thighs, and sometimes in his chest. He said that the pains were very peculiar, “as if the flesh were screwed up and then let go again;” they would come on at any time, and would sometimes make him stop suddenly when walking. Not unfrequently they would wake him in the night. They seldom lasted more than for a few minutes at a time. He said it was more than three or four years since the liability to them began, but that the frequency of attacks had much increased of late. As his father had suffered much from gout, he had until lately considered that they were of that nature. Latterly, however, their frequency and severity had been such that he had doubted this diagnosis. Another

peculiar symptom had been gradually developing, *pari passu* with his pains. He had become quite unable to get into a hot bath. If he did so, it produced not a sensation of scalding of the skin, but a deep aching of the limbs which was quite intolerable. In using a warm bath he was obliged always to get into it at a tepid heat, and then gradually turn on the hot water. In this way he could increase it up to 98° with comfort. I found that his pupils were very sluggish, the left, indeed, was almost motionless. Both were larger than usual, and the left was larger than the right. His accommodation was good; he had had no bladder-symptoms, and he could walk with perfect ease with his eyes shut. His knee-jump was poor in the left, but fairly good with the right.

I can have no doubt that the symptoms mentioned were the very slow beginnings of tabes; but as the patient thought that his pains were definitely influenced by his diet, I do not think it improbable that they were, in part, of a gouty nature; and I advised him to put himself under a careful regimen in the hope of their prevention.

Another case, which I may place by the side of the preceding, and to some extent in contrast with it, is that of Mr. M— H—. This patient, a man of 41, had a family of nine healthy children. In early life, however, before his marriage, he had suffered from syphilis. He was apparently in good health, and was under my treatment only on account of a superficial rodent ulcer on his nose. One day after I had seen him on this ailment, he mentioned to me that he had of late been much troubled with nocturnal incontinence of urine. I passed a bougie, and found that he had no stricture; and it became, therefore, somewhat difficult to explain such a symptom in a man of his age. He threw some light on it, however, by reminding me that three years ago he had consulted me on account of pains in his lower limbs, and that I had prescribed anti-pyrine to be taken at bedtime. On referring to my notes, I found that I had written against his name on October 14, 1891, "Ataxic pains." The disease had made no great progress, and his

chief complaint was that he tired much more easily than formerly. Micturition, he said, was very feeble, and his sexual vigour was rapidly failing. His knee-jump was decidedly excessive.

The explanation of nocturnal incontinence in tabes may possibly be simply defective sensation in the neck of the bladder, thus allowing the patient to sleep through a call which would otherwise awake him. I found that this patient, in spite of his annoyance, was still in the habit of drinking a couple of glasses of whisky-and-water before he went to bed. I had, therefore, no difficulty in telling him how I thought he might be relieved.

No. XLVI.—*Cases illustrating Syphilitic Disease of the Nervous System.*

There are few cases more difficult for prognosis than those in which the nervous system suffers in syphilis, and I have thought that the three cases which are to follow (in tabular statement) are worthy of record in reference to this matter. In all, the history extends over a long series of years. The cases have no special connection with each other, beyond the fact that they were all examples of nerve disorder after syphilis.

In the first (No. 46), the chief feature of interest is the permanent and almost complete recovery after a very severe cerebral illness. The liability to epilepsy entirely ceased under treatment, and the patient, although he remained quite blind, regained his health and was able to marry.

The points in the second case (No. 47) are : first, that the patient had two definite attacks of syphilis, and, secondly, a very long duration of tabetic pains of considerable severity, but without other marked symptoms.

The third case (No. 48) is one in which ophthalmoplegia, which threatened in the fourth year of syphilis, was warded off by specific treatment, and did not occur till ten years later.

I have stated them all in the space-for-time method, which will, I believe, much facilitate the reader's appreciation of their facts.

No. XLVI.—*Permanent recovery from Meningeal Gumma.*

*Syphilis. Epilepsy repeated and frequent, with severe headaches, in fourth year. Optic neuritis and rapid total blindness. Recovery under treatment. Disease in nose ten years later. Good health (with total blindness) thirteen years after the attack. Enormous doses of iodide.*

AGE.	DATE.	DETAILS.
25	1870	Chancres on penis for first time (indurated).
26	1871 (1)	Secondary eruption all over his body. Treated imperfectly.
27	1872 (2)	Well, but with reminders.
28	1873 (3)	Epilepsy: frequent from August to March. Severe headaches and great loss of health, and confined to bed.
29	1874 (4)	He became totally blind. The epilepsy ceased soon after.
30	1875 (5)	No epilepsy. Improving.
31	1876 (6)	No epilepsy. Improving.
32	1877 (7)	Return of epilepsy; a single attack.
33	1878 (8)	Gaining ground.
34	1879 (9)	Gaining.
35	1880 (10)	In fairly good health.
36	1881 (11)	Married (no conceptions followed).
37	1882 (12)	In fair health, and accustomed to much brain work.
38	1884 (13)	In fair health.
39	1885 (14)	Anæmic; ulceration in nose. Septum perforated (a very
40	1886 (15)	small hole). In fair health.
41	1887 (16)	Seen by me for first time. Quite blind, but in good health. I advised no further treatment unless symptoms should occur.

He was treated for his headaches and epilepsy by mercury, &c., and got rid of them about the time that his sight failed. He was in bed prostrate with headache at the time that he lost his sight, but he never had any paralysis.

About six months after the sudden failure of sight he regained bare perception of light, but has not improved since. He still has perception of light, and just managed to count the windows in my room, mistaking a mirror for one.

He used to have "dead-ache" in his legs (shin-bones)—"excruciating pain"; kept him awake at nights. He had no lightning pains.

Divergence of right eye, but no paralysis of muscles. Pupils of normal size, No. 4. No knee-jump, but there are no other signs of tabes. He avers that his sexual power is good. Optic discs white and atrophied.

In 1885 he took two-drachm doses of iodide three times a day for six weeks continuously, for the disease in his nose. It suited well.

He seems well, and says that if he could see, he was never better in his life.

His fingers go to sleep easily, and become dead from any slight pressure. It is possible that his very large doses of iodide may have caused this liability.

*COMMENTS.*—*This case is of much interest in reference to the prognosis of cerebral syphilis. There can be little doubt that in the years 1873-4 the patient had a meningeal gumma which caused his terrible headaches, epilepsy, and optic neuritis. From this he wholly recovered, and has preserved good brain health for thirteen years. He has married since this illness, and although he may still possibly pass into locomotor ataxy, the cure of the gumma seems to be permanent.*

No. XLVII.—*Tabes after Syphilis.*

*Tabetic pains four years after Syphilis. A second attack of Syphilis. Continued liability to tabetic pain, sometimes severe, for more than twenty years. Diagnosis of Tabes in twenty-fifth year. Repeated attacks of Diplopia. Impotence. Defective articulation, gait, and use of hands.*

AGE.	DATE.	DETAILS.
22	1856 (1)	Syphilis complete.
23	1857 (2)	
24	1858 (3)	
25	1859 (4)	
26	1860 (5)	Lightning pains in legs and soles of feet.
27	1861 (6)	Went to China. A second attack of syphilis; no secondary symptoms.
28	1862 (7)	"Sciatica"; lightning pains. General debility.
29	1863 (8)	At home; still pain.
30	1864 (9)	At home.
31	1865 (10)	At home.
32	1866 (11)	At home.
33	1867 (12)	West Indies.
34	1868 (13)	West Indies.
35	1869 (14)	West Indies.
36	1870 (15)	West Indies.
37	1871 (16)	India.
38	1872 (17)	India; came home.
39	1873 (18)	At home.
40	1874 (19)	India.
41	1875 (20)	India.
42	1876 (21)	MARRIED. In good health, but liable to attacks of pain.
43	1877 (22)	India. In good health.
44	1878 (23)	India.
45	1879 (24)	Diplopia. Dr. H. J. diagnosed Ataxy for first time.
46	1880 (25)	
47	1881 (26)	At home. Got rid of his pains by blistering and iodides.
48	1882 (27)	At home and Ceylon.
49	1883 (28)	At home.
50	1884 (29)	At home.
51	1885 (30)	Ceylon. Third attack of strabismus. Large doses of iodide.
52	1886 (31)	At home.
53	1887 (32)	Jamaica; could still walk about well; speech became thick.
54	1888 (33)	July; comes to me (only just home from Jamaica).

Pupils very small and quite motionless. He sees nearly  $\frac{2}{3}$  with either alone; either alone is better than the two together. He reads No. 1 with his glasses.

No girdle pain, nor any gastric crises at any time; no throat pains. Has had three transitory attacks of diplopia and strabismus.

Bladder: no derangement of function. Bowels: habitually constipated.

He walks unsteadily. There has not been the slightest knee-jump for some years.

He sleeps well. He never had any seizure or fit.

He speaks very thickly, but very seldom fails to enunciate a word.

He does not look ill. He walks badly, and only by aid of a stick. Impotence, now complete, has been progressing for several years. He says that he cannot write easily.

For some years the pains have been absent until quite recently, when they have relapsed. The thickness of speech is a peculiar and exceptional feature in Ataxy, and may indicate the approach of general paralysis.

He thinks that iodide of potassium does not depress him. Has taken much. Blisters have, he thinks, relieved the pains.

One of the most interesting points in this case is the long continuance of the pains before the other symptoms of tabes declared themselves. He is an intelligent man, and states that for twenty-five years he has been liable to most characteristic and severe pains in his limbs.

No. XLVIII.—*Ophthalmoplegia after Syphilis.*

*Unsymmetrical Ophthalmoplegia in fourth year of Syphilis. Absence of most of the symptoms of Tabes. Knee-jump excessive in fourteenth year. Permanent loss of accommodation in one eye.*

AGE.	DATE.	DETAILS.
24	1875 (1)	Syphilis complete; mercury for some months.
25	1876 (2)	Well.
26	1877 (3)	Well. Lost his voice. Saw Dr. M. M., who treated for syphilis. No relapse.
27	1878 (4)	Drooping of right eyelid and double vision. Treated by specifics.
28	1879 (5)	In good health. In excellent nerve.
29	1880 (6)	Good health.
30	1881 (7)	Married in June. In good health.
31	1882 (8)	First child born. It lived, and is healthy.
32	1883 (9)	Good health.
33	1884 (10)	Second child born. It lived, and is healthy.
34	1885 (11)	Good health.
35	1886 (12)	Good health.
36	1887 (13)	In April had double vision. He consulted me in November.
37	1888 (14)	Ophthalmoplegia, &c. State described in notes below.

He looks well, but a little bloated. He lived freely in former days; he was very vigorous sexually.

"Go to sleep sort of pain" in feet. Never kept awake. He still rides and hunts, but not so well as he did. Very liable to stiffness after riding.

The right eye has a tendency to turn inwards and cause squint. Is this from the effort to accommodate?

Right eye-pupil large and motionless. Accommodation quite lost. Vision with +10 perfect.

Left eye-pupil almost motionless. Accommodation good.

He can walk firmly with his eyes shut.

His micturition is weak, and he is unable to finish.

It is probable that many of the eye-muscles are defective, but it is very difficult to test them. In looking upwards he sees a dazzling, which is a sort of double vision—thus he usually sees two moons. The only definite defect is in the external recti.

1888, Sept. 8.—He has never had stabbing pains, nor any material pain of any kind in legs. He is liable to pain in the toes at night much like gout.

His urine sometimes escapes at night. Micturition weak. He complains of pain at root of penis.

Knee-jump still excessive.

He has some sexual desire, but is very weak. Pulse soft and feeble.

Some neuralgic pains in right side of face.

No. XLIX.—*Hæmorrhagic Retinitis eighteen months after Syphilis.*

A case of some interest as an example of hæmorrhage into the retina came under my observation in the person of a gentleman named F. B. Y—, on November 27, 1892. He had suffered from syphilis in April, 1891—that is, about twenty months previously; and he had been taking medicines, chiefly iodides, almost ever since. The history as regards his eye was that in October of 1891 he had an attack of inflammation in the right eye, which lasted two weeks, and left the eye weak. In the following May, on waking one morning, he saw what he calls “veins” before him; but more recently this appearance had changed to a movable cloud. When he came to me he was quite free from specific symptoms. He could see perfectly with his left eye, but only  $\frac{2}{3}$  with the right; with the latter he could see better when looking downwards. He described what he saw as looking like a dark blot of ink, which hovered about in the upper part of his field of vision, and would sometimes come down and then float up again. The ophthalmoscope revealed a very large area of the retina bloodstained. The film of blood was very thin, and although in parts it concealed the retinal vessels, in others they could be seen through it. The margins of the patch were very abrupt; the optic disc was bloodstained over the whole of its surface, and near to it was a dense thick blur of dark blood.

Mr. Y— was taking the three iodides in combination at the time he came to me, although he had no symptoms of syphilis. There was, I believe, a history of gout in his family, but I could not obtain any facts indicating special tendency to hæmorrhage. He had not suffered from bleeding at the nose, nor had he had constipation. His age was about 26.

## PLATE XCIII.

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### TUMOURS IN THE CAUDA EQUINA.

THIS engraving is copied from one that was published in the 'Transactions of the Provincial Association,' by the late Dr. Fisher, Down Professor of Physics at Cambridge. It represents a mass of tumours connected with the Cauda Equina, respecting the pathological nature of which I must be content by transcribing Dr. Fisher's own words:—

"The tumour or rather mass of tumours, on which a great number of vessels are spread, was surrounded on all sides by the roots of the nerves forming the Cauda Equina. The lower portion of this morbid growth had the form of a tubercle. It presented several traces of vascularity in the centre, and had a scirrhus appearance; I could not, however, make anything out satisfactorily with regard to its minute structure. The upper portions of the tumour were softer, and were involved in a fine glistening covering; sections of several portions of them show them to be composed of a grey, semi-transparent, jelly-like substance, infiltrated amidst reticulated tissue, and marked with sanguineous striæ, several of which appear like two vessels."

Dr. Fisher further adds that the dura mater and arachnoid appeared to be quite healthy, and that the cord itself was also sound. Some of the nerves appeared to pass through the tumours, but the greater portion of them could be easily detached. There can, I think, be little doubt, when we regard the case in the light of more recent experience, that the tumours were of the nature of fibromata. The case is of much interest in reference to one at least of those given by Mr. Robert Smith in his splendid monograph.

A reference may also be made to two preparations which are in the Institute of Pathological Anatomy at Vienna, and which I have briefly referred to at page 142, 'Archives,' Vol. iv. These two

PLATE XCIII. (*continued*).

specimens are regarded by Professor Kundart as examples of multiple gummata in the Cauda Equina. Excepting that the tumours were more fusiform, Professor Kundart's specimens much resembled the appearances shown in this lithograph.

To return now to the history of Dr. Fisher's case. The patient was a man aged 38. He died in May, 1840, having been nearly six months under Dr. Fisher's observation. It is recorded that he had been intemperate in his habits, but nothing is said as to syphilis. He believed that he had injured his back, in riding, about three years before his death, and from that time onwards he had suffered from pain in the loins, which was at first called rheumatism, but which gradually increased in severity and extended down the legs. One year before his death he was obliged to desist from his occupation as a tailor, and a few months later still he became bed-ridden. He was unable to lie down, but rested on his hands and knees. There was great numbness in the lower extremities, more especially in the left leg. He had difficulty in making water and some incontinence of urine. He was entirely free from symptoms in reference to his head, chest, and upper extremities; and notwithstanding the awkward position which he was compelled to take, he did some work as a tailor till within a week of his death.

There were large pressure-ulcers on his knees, which however gave him no pain.

It will be seen that the above history fits well with the slow growth of fibromata; and that there is nothing suggestive either of syphilis or of any infective form of malignant growth.





## THERAPEUTICS AND DIET.

### No. XXIX.—*Chrysophanic Acid in Lupus Erythematosus.*

I have, during the last two years, frequently employed weak ointments of chrysophanic acid for the treatment of lupus erythematosus, and have, on the whole, had much reason to be pleased with the results. Two especially satisfactory cases are at present under my observation. One of them, a shop girl, was so much disfigured by the patches on her face, for which she had already had much treatment, that she said that she should be obliged to give up her situation unless something more could be done. I gave her the chrysophanic acid ointment, five grains to the ounce, and instructed her to use it very sparingly. The first result was to make the patches much less conspicuous by making the whole face of a reddish-brown colour. When this subsided, which it did quickly, the patches were almost gone. She is still under treatment, but the patches are not now to be recognised, unless carefully looked for. The case was one of the most purely erythematous forms, and occurred on a fair skin. I have had several cases of absolute cure, nothing being left but very faint scars. Amongst the best of these I may mention that of an exceedingly handsome young lady, of a brilliant complexion and a somewhat phthisical aspect. In her the disease was only of a few months' duration and not severe. It consisted only of a few discs of scaly erythema, symmetrically placed on both cheeks. A six weeks' very sparing use of the ointment has so completely removed these patches that I had much difficulty in discovering their sites. On very careful inspection, however, I found

that there were some very slightly marked scars. Her mother told me that she observed them only at night, when her daughter chanced to be somewhat flushed, and that then they showed up as slightly white, being paler than the rest of the skin.

No. XXX.—*Note on the beneficial effects of a Mercurial Course.*

The effect of a vigorous mercurial course, although it would be very depressing at the time, is, I believe, beneficial to the health afterwards. An instance of this occurred in the case of Mr. J. H——. This gentleman inherited gout, and twenty years ago I had treated him for syphilis. He had married, and been perfectly well for almost the whole of this period till he began to suffer from rheumatic gout in his knees. He had considerable swelling in both, and some one having suggested that this was probably syphilitic, he was sent off to Aix-la-Chapelle. There he used the sulphur baths, and had also liberal inunction of mercury to full ptyalism. He found it, as he said, a very severe treatment, and was much pulled down, but the result was that his knees got quite well; and, during the next two years, he enjoyed much more vigorous health than he had ever known before. At the end of the two years he came to me suffering from rheumatic gout in one foot, but still in excellent health.

No. XXXI.—*On the Medicinal employment of Coffee.*

I have often been in the practice of prescribing coffee as a medicine in certain states of great debility. It appears to me to be a remedy quite unique in its usefulness in sustaining the nervous energy in certain cases. Apart from its general usefulness, I have found it of especial service after operations where anæsthetics had been used, and in states of exhaustion where alcohol had been pushed and a condition of semi-coma followed. In these latter cases I have sometimes prescribed it as an enema when the patient could not swallow, and with the best effects. Its value as an antidote to opium is of course

well known. Tea and coffee seem to me to be much alike in many respects, but I would give great preference to the latter as to its sustaining power. It would, I think, be a great advantage to our working classes, and a great help towards the further development of social sobriety, if coffee were to come into greatly increased use and if the ability to make it well could be acquired. As an example of the difference of effect of tea and coffee upon the nerves I may note, what I believe many sportsmen will confirm, that it is far better to drink coffee than tea when shooting. Tea, if taken strong or in any quantity, especially if the individual be not in very robust health, will induce a sort of nervousness which is very prejudicial to steady shooting. Under its influence you are apt to shoot too quickly, whereas coffee steadies the hand and gives quiet nerves. My object in the present note is, however, to illustrate the remarkable power of coffee as a restorative medicine.

In the case of an old man in whom colotomy was done in a very desperate stage, he being almost moribund, good rallying took place under injections of coffee and milk. During the first two or three days great use was made of coffee, and I believe that the recovery that resulted was largely to be credited to it. I have employed it in many similar, though less severe, cases. It is my almost invariable prescription for elderly people after an operation for which an anæsthetic has been given. One of the most remarkable facts, however, which I have ever witnessed, illustrating its powers, was the following. I was called late one evening to an elderly lady whom I had repeatedly seen previously on account of multiple sarcomatous growths in her bones. She had been in an almost dying state for more than a month, and at length it seemed that her end was come. I found her in a state of deep collapse, with pale face and dusky lips, and unable to speak or recognise any one. Her breathing was short and rapid. Her daughters were attempting to force brandy into her mouth by the spoon, but she could not swallow it, and I learnt that they had given a good deal of champagne and brandy during the afternoon. Her pulse, although very rapid, still beat well, and was not in keeping with her other symptoms of collapse. This made me

think that probably more alcohol had been given than was useful, and I resisted the importunity of the relatives that subcutaneous injections of ether should be made. Feeling sure that she was sinking, and expecting that all would be over in an hour or two, I wished to take my leave. The patient's daughters, however, in great distress, begged me to stay to the end. I waited about an hour, still refusing to administer more alcohol. At the end of that time the nose had become cold, and the face was bedewed with a clammy sweat. It was under these circumstances that, in consequence of the urgent solicitation to do something, I thought of trying a coffee enema. After the nurse had prepared it, she appealed to me as to whether she should give it, evidently thinking, as I did, that it was absurd to attempt anything in a patient so nearly dead. It was, however, administered, and with the surprising effect that within a quarter of an hour the patient opened her eyes and recognised those about her. In another half-hour she spoke to us, and colour began to return to her face. The coffee was repeated several times during the night, with the addition of some very small quantities of brandy. The result was that the patient recovered and lived on for three weeks afterwards.

In this instance I have no doubt that alcoholic stimulants, whilst they sustained the circulation, had acted injuriously on the nervous system, and that the patient, already extremely weak, had been pushed into a condition approaching that of intoxication. It is, I believe, very easy on the death-bed to over-use alcohol, although in the case which I have narrated, the disease being incurable and the suffering great, the prolongation of life for a few weeks was not a matter of real importance. There are, however, many others in which death may be close at hand where an expedient such as that which I have described may be the means of permanent restoration to health.

No. XXXII.—*Record of individual experience as to Diet in Gout.*

Mr. D——, a general in the United States Army, aged 51, gave me some interesting items of his personal experience re-

specting gout. He was a man of pale, earthy, almost leaden complexion, but still enjoyed fairly vigorous health, and had no conspicuous tophi. He had suffered, however, many and very severe attacks of gout in the great toe and other joints. He said that his grandfather, who was an Englishman and who was the first of the family to settle in the States, suffered from gout, and was during the last years of his life quite crippled. Neither his father nor any of his uncles suffered. He had himself lived freely all his life, and in spite of his gout he alleged that he still continued to eat and drink everything. I found, however, on detailed inquiries that there were limits to this assertion. He admitted that he dared not eat sweet fruits, more especially gooseberries, and that he believed that tomatoes had more than once given him gout. Burgundy also he was sure was very efficient in the same direction. Port was his favourite wine, and he still took it pretty freely and found no harm from it. Although he had at one time for two months been wheeled about in a bath-chair, he was now quite free from crippling, and he consulted me about an ailment unconnected with his gout.

No. XXXIII.—*Use of strong solutions of Tar in Eczema.*

I have on many occasions strongly advocated the use of tar-washes as being by far the best remedy for almost all forms of eczema. My favourite combination is a preparation of tar in the form of liquor carbonis with solution of acetate of lead. In most cases it seems to succeed best when very freely diluted; but I am accustomed to employ it according to its effect in very various strengths. A teaspoonful of each of the solutions named to a pint of warm water is a very common prescription; but it requires to be used, not only as a wash, but to be kept constantly applied on lint. In some cases a more convenient mode of application is a very much stronger preparation applied to the affected parts for only a few minutes at a time. The undiluted liquor carbonis alone is often very effectual for the relief of pruriginous affections. It stings at the moment of its application, but it relieves the

itching and does not cause smarting afterwards. A medical friend of mine, for whom some years ago I prescribed liquor carbonis with lead in a diluted solution, tells me that he has found it much more convenient and effectual in the stronger form. He uses equal parts of Wright's Liquor Carbonis and the Liq. Plumbi Diacetatis. Without adding any water, he takes a little of this solution in the palm of the hand and rubs it gently for a few minutes over the eczema patch. His experience is that it always kills the disease.

No. XXXIV.—*Ptyalism from the local use of the Ammonio-chloride of Mercury.*

It is necessary to bear in mind, when we prescribe ointments containing the ammonio-chloride of mercury, that the patient may possibly use them so freely as to produce salivation. The ammonio-chloride is usually regarded as an almost insoluble salt, and is often prescribed as if no hurt could come from it. In the vast majority of cases this is quite true, but we must not rely upon it too confidently. I have myself been in the habit of making the ammonio-chloride a constituent in a great number of the prescriptions which I have written for the treatment of eczema and other affections of the skin; its efficiency is very definite; but on at least three occasions I have been informed of its having produced rather severe salivation. In all cases it was in patients who were using the remedy very freely without remaining under supervision. I do not think that any inconvenience would be ever likely to result, if the patient were under the notice of a medical man. Ill consequences may, however, ensue when, in consequence of no suspicion being entertained, the ointment is still continued in use after the symptoms appear. Under these conditions two of my patients, one of whom had left England on a long voyage, were made very seriously ill. A knowledge of the fact is of considerable importance in two directions; first, in order that we may be on our guard, and either warn the patient beforehand as to what symptoms he may expect, or insist on his remaining under supervision during treatment; secondly, it is not without interest for us

to know that in using white precipitate ointments we are really, in a mild way, giving mercury, and may thus at the same time be benefiting the patient's health whilst we are thinking only of the cure for his local malady. I have long been in the habit of prescribing this ointment for syphilitic eruptions, in addition to giving a remedy by the mouth. It certainly assists in procuring the disappearance of the spots, and when the surface affected is considerable, it very probably helps also against the constitutional disease.

What has been said above, as regards the necessity for caution in the use of ammonio-chloride over large abraded surfaces, probably applies also to most of the other salts of mercury—calomel, the red oxide, yellow oxide and others. We do not, however, as a rule, employ these salts so freely as the white precipitate.

## NOTES ON OPERATIVE SURGERY.

### No. XVIII.—*Prostatectomy for Bladder Obstruction.*

The treatment of prostatic retention of urine, by means of operation, has, I think, received a very important simplification. As practised by the late Mr. McGhie and his colleagues at Leeds, to whom so much credit is due for taking the initiative, it was a very formidable procedure. It consisted, as then practised, in the removal, not only of what used to be known as the middle lobe, now re-named the vesical lobe, but of a considerable portion of the lateral lobes as well. The more recent proposal, and the one advocated by Mr. Buckstone Brown in his paper a few weeks ago at the Medical Society, recommends that the lateral lobes should be left untouched. This seems to be a very practical and common-sense proposal, for it is the projecting and valve-like vesical lobe which alone constitutes the impediment. The removal of this part only may be accomplished with comparative ease, for it is isolated and has a comparatively narrow base. It is easily accessible after opening the bladder above the pubes. Although I do not doubt that the supra-pubic opening affords the best means of reaching it, yet it will be well to remember that in former days when lithotomy was in vogue, it was not infrequently removed from the perinæum during the performance of that operation. Observations are not wholly wanting as to the benefit that accrued to patients who permanently recovered from their prostatic troubles after this occurrence. The cases to which I refer were, in the main, instances of unintentional removal of the lobe in question during the extraction of the stone. I have seen this done by several operators, and I especially well remember cases in which it occurred to Mr. Syme and Sir William Ferguson. I have had at least

three myself. Concerning one of these I am able to carry the narrative through a period of several years after the operation, and it may be worth while to record the facts.

About four years ago I was consulted by a gentleman who was extremely ill from cystitis, and who had been troubled for some time by incomplete prostatic retention. He had been under the care of a specialist up to the time of my seeing him, and had, after repeated soundings, been assured that there was no stone, and that what he had to do was to patiently continue the use of the prostatic catheter. As his sufferings were extreme and he was obviously not likely to live long unless relieved, I advised that a cystotomy should be done and the bladder explored. As the use of the sound gave him great pain, and as it had been recently employed in highly skilled hands, I did not resort to it until he was on the operation table under an anæsthetic. I then opened the bladder in the usual way by the lateral incision, and having forced my finger through a long prostate, I had the pleasure of finding a stone of very considerable size, which had been concealed behind a projecting third lobe. The stone was, without much difficulty, seized; but the extraction brought away in front of it a portion of prostate as large as a half walnut. Having ascertained that the bladder did not contain any other stone, I next proceeded to deal with the torn prostate; and partly by forceps, partly by the finger, took away portions altogether at least as large as that at first extracted. The passage into the bladder was now quite clear, and the operation was concluded by the insertion of a large india-rubber tube for the purpose of drainage. The patient, although a feeble man of 65, made an excellent recovery. He has never needed to use the catheter since. All traces of cystitis have vanished, and he can now both hold and void his urine in a perfectly natural manner. It is more than four years since the operation was done, and I have seen him quite recently.

The result in the above case affords much encouragement in reference to the performance of the modern operation, for nothing except the vesical lobe was taken away.

No. XIX.—*Ligature of the Brachial Artery for Wound.*

I had an opportunity of examining the condition of an arm after obliteration of the brachial artery, in the person of C—— M——. This gentleman, aged 29, had been injured whilst out pig-sticking, by the point of a spear which entered the inner side of his right upper arm. The profuse hæmorrhage was arrested at the time by bandaging, but an aneurism formed, and it became necessary to lay it open and tie the brachial. The operation was performed in India. In the end he made a good recovery.

When I saw this patient about eight months after his operation, everything had for long been quite sound. There was, however, no pulse to be recognised at the wrist, and the hand looked somewhat dusky, and felt quite cold. There was no evidence of any injury to any nerve, and C—— M—— said that he had regained almost complete use of it.

No. XX.—*Results of Operations for Un-united Fracture of Humerus.*

Some years ago I was consulted by a gentleman who had an un-united fracture in the middle of his right humerus. By the assistance of a leather case he could use his arm very well, and I advised him, as I have done several others in like condition, to be content with it as it was, and not to submit to any operation. This he decided to do; but after several years, coming under the care of a more zealous operator, he was persuaded to have the bone wired. This was done, and successfully, for the bone is now united, and the operation-wound soundly healed. He is not, however, by any means exultant at the result, for although about a year has elapsed, the arm is not so useful as it was before. He had a long and troublesome illness after the operation: abscesses burrowed, and required to be opened below the elbow, and many small portions of bone were exfoliated. The operation altogether kept him many months from business, and, he thinks, injured his health. In reviewing

the case, I am inclined to think that my advice was good. During the last ten or fifteen years, I have had under observation three or four examples of un-united fracture in the middle of the humerus. All of them were in gentlemen in robust health, and pursuing active occupations, and to all I gave the same advice, to be content with the support of a leather splint strapped round the upper arm. In all the use of the member, aided by this appliance, was tolerably good. I believe that they all, at one time or other, obtained the advice of other surgeons, but, with the exception of the one whose case I have just recorded, I believe that none of them received opinions sufficiently favourable to operation to induce them to submit to it. One of them was a sportsman, and could manage his gun very fairly in the field. One of them consulted a very distinguished surgeon, to whom he was introduced by a mutual relative. He received, as he told me afterwards, this opinion, "If you come to me as a friend, I say 'let it alone': but if I am to speak as a surgeon only, the right thing is to operate." This expression very well represents my own feeling on the subject. If I had an old-standing un-united fracture of the humerus, and were able to manage the arm pretty well with the aid of a splint, I would not—knowing what I do of the uncertain and frequently imperfect results of operations—seek the performance of one.

No. XXI.—*Successful Amputation in a case of very painful stump with contraction.*

A case which I reported briefly two years ago was that of a man who had sustained an injury to his thumb, and in whom the thumb had afterwards become painful and been amputated. The pain persisted in the stump, and the whole of his fingers became contracted into his palm. The hand was quite useless, and was, besides, the cause of great suffering. The man attended for demonstration at one of my post-graduate lectures, and I also had a photograph taken. It became a matter of great importance to estimate the probable results of another amputation. The removal of the thumb, which at the time was supposed a radical

measure, had quite failed to arrest the neuralgia. Indeed, the conditions had become much aggravated since the operation. The man had been a patient both at the London Hospital and at the Hospital for the Diseases of the Nervous System, in Queen's Square, and neither internal remedies nor the local use of anodynes had effected anything. Under these conditions, although well aware that many similar cases had ended in disappointment, I yet felt justified in recommending the man to have an amputation done through the forearm. The operation was performed at his home in Barnet, by my friend Dr. Thyne. This was more than a year ago, so that I am now in a position to report as to what may be fairly deemed as the result of the case. Dr. Thyne sent the patient up a few weeks ago for my inspection. The man is now in excellent health, and has a very good stump. He has been quite free from pain ever since the operation, and is able to follow his occupation without inconvenience. We may therefore consider that the amputation has been a complete success. His only complaint is that he feels the cold in his stump. It is, of course, within possibility that the neuralgic condition may yet develop in it, but the period of trial having been considerable, we may be hopeful on this point.

No. XXII.—*Excision of the Tongue for Cancer—  
Cases illustrating very rapid implication of the  
lymphatic glands.*

I operated on Mr. R——'s tongue at Brighton, in consultation with Mr. B—— of that place. The cancerous ulcer was very small, and had been considered, before I saw him, to be ill-marked. I felt no doubt about the diagnosis, and the microscope confirmed it. The operation consisted in the removal by the ecraseur of the right half of the tongue. The ulcer was on the right side, a little behind the middle. About six months after the operation I was asked to see Mr. R—— at Blackheath, and was much disappointed to find a large glandular mass under his sterno-cleido. He had also another enlarged gland under the jaw. This latter could easily

have been removed, but the mass in the neck was low down and involved many glands; it also passed under the cover of the muscle behind the clavicle. Its position was such that it was quite hopeless to think of removing it. I never in any other tongue case saw a gland mass in precisely this position, nor ever knew so many glands to be enlarged at once, and so quickly. The glands under the upper third of the muscle, which are more usually involved, were not implicated. It is these latter which are more usually attacked.

Within a few days of my seeing Mr. R——, I saw also another patient on whom I had operated about the same time and under very similar conditions. Mr. B—— had been sent to me from Dublin, and I removed from his tongue just such a piece as was taken from Mr. R——. In each instance, those who had seen the case previously thought that the disease was not cancer, and it was on the smallest possible scale. Mr. B—— came to me about six months after the operation, with a hard enlarged gland, quite movable, just under the angle of the jaw. I advised its immediate removal, and he returned to Dublin for that object. We may note that in both these cases the tongue itself remained perfectly sound after the operation. The responsibility of the return in the glands in such cases clearly rests with those who fail to take alarm early enough. Had the rule been adopted to excise freely everything that looks doubtful, I have no doubt that both these patients might have remained without any recurrence. One of them was the father of a large young family, and his life was in other respects of especial value. Both of them were just under fifty years of age.

### No. XXIII.—*Distal Ligatures of Arteries for Thoracic Aneurism.*

Dr. Potter was good enough to show me, during a visit to the Kensington Infirmary, a patient in whom distant ligature of arteries for a thoracic aneurism had been performed some months previously. It was on January 6, 1893, that I examined the woman, and the operations had been done

in one of our London hospitals, in May and July of the preceding year. In the first instance the carotid and sub-clavian had been tied, and on the second occasion the axillary. When I saw the woman no pulse whatever could be detected at her wrist; a visible aneurismal swelling projected through the upper part of the sternum, or, apparently, through the sterno-clavicular articulation. It pulsated very freely, and the skin was beginning to thin, but there was no danger of immediate rupture. I asked the woman whether it was her impression that any of her symptoms had been relieved by the operation, to which she replied in the negative. She did not appear, however, to suffer much from her disease, and said that if she could lie quite still in one position she had but little pain. The tumour could be felt pulsating quite freely and rather forcibly above the clavicle. I should conjecture in this case that the vessel involved is the arch of the aorta rather than the innominata.

We have in the London Hospital a very valuable specimen showing complete cure by lamination of an aneurism of the innominata. I published a description of this specimen in some Museum Notes in the *British Medical Journal* for 1870. In that case the cure was brought about by rest and repeated venesection.

## MISCELLANEOUS.

### No. XCIII.—*Some general statements as to the Laws of Pathological partnerships.*

Fundamental in all pathological partnerships, we have the intrinsic vital endowments of the body affected.

The endowments just referred to are of various kinds, and affect different tissues. They may be general or only local.

These inherited endowments may concern anatomical and physiological peculiarities only, or they may be the results of disease in predecessors, and thus of a definitely pathological character.

These intrinsic endowments receive modifications by the age of the individual, and may reveal themselves in very different ways in infancy, in youth, in adult age, and in senility. Age must therefore very often be reckoned an important partner in disease.

The sexual system, for the most part in abeyance in youth, very active in adult life, but in very different degrees in different individuals, and again in senility for the most part in abeyance, must in very many diseases be counted as active partner.

Some partnerships may consist solely of an inherited peculiarity with some external or postnatal influence, which has been brought to bear upon it.

In some cases several inherited peculiarities distinct in their nature may combine together to evolve a mixed form of disease.

To the mixture of hereditary peculiarities pre-supposed in the preceding sentence, there may be added some external influence or parasitic infection, and thus a still more complex result may be produced.

In some cases the partnership may be simply that of a zymotic parasite with the natural forces of a healthy body.

In others, the combination may be between a zymotic parasite and special inherited peculiarities, and these latter may vary almost infinitely in character.

The term hæmorrhagic variola does not designate any peculiarity in the variolous poison, but rather the results of the influence of that poison upon tissues peculiar in their endowments in reference to a tendency to bleed.

No. XCIV.—*Displacement of the Patella after Arthritis without Anchylosis.*

A man aged 22, very tall and lanky, was the subject of a very peculiar condition in his left knee-joint. By a complete dislocation of the patella on to the outer side of the external condyle, the whole of the front of the articulation was left exposed. He could flex and extend the knee quite freely, and when flexed, the condyles and the trochlea projected under the skin. Although the patella was freely movable, it could not be replaced. The tibia was straight under the femur when he stood up, but with a certain amount of rotation outwards. The whole joint was loose, and the tibia could be moved laterally, and rotated much more than was natural. The quadriceps was wasted, and he was quite unable to lift the limb from the bed when it was extended. There was no inflammation about the joint, nor any swelling of soft parts, nor alteration in the shape of the bones. The man attributed the condition to an attack of gastric fever when he was an infant a few months old. In confirmation of this suggestion there were the scars of three abscesses, above and below the joint. A very unusual feature in the case was that the joint had not been in any way stiffened.

No. XCV.—*Recovery after Fracture of Base of Skull in a boy.*

A gentleman who consulted me in 1886 on account of defective refraction, and in whom I found that one facial nerve was

partially paralysed, gave me an interesting history of recovery from an injury in which no doubt the base of the skull was fractured. His head had been crushed in a railway accident, and he had afterwards been three months in bed for an illness from which he was not at all expected to recover. It had left him permanently and absolutely deaf in the left ear, with considerable weakness of all the muscles supplied by the left facial nerve, and partial paralysis of the left sixth nerve. The optic disc in the left eye was also a little hazy, suggestive of bygone neuritis. The accident occurred when he was thirteen years of age, five years before I saw him, and was attended, I believe, by free hæmorrhage from nose and ear.

#### No. XCVI.—*A Case of Blanched Eyelashes.*

The following narrative of an example of local blanching of the eyelashes in association with neurosis has been supplied to me by my friend Mr. Debenham, of the Commercial Road :—

“A very neurotic woman, æt. 29, fair, with reddish auburn hair, was brought to me with hysteria, bordering very closely upon insanity. Her appearance was striking, owing to the lashes on the *inner* half of the upper lid of the right eye being *quite white*—strikingly so. The whiteness began in one lash only *in the centre*, and from that spread inwards to the nose. This occurred ten years ago on a voyage from Australia. There are no grey hairs in the head, but latterly some have shown in the inner quarter of the right eyebrow. She has had no blow or injury, or inflammation about the eye; no illness, and no neuralgia or headache; but there is a mark of a leech-bite close to the outer canthus of the right eye, which she thinks was put on after a severe attack of measles, which she believes caused her at that time some temporary blindness (at the age of 5). Her health has been always good. Her mother died of phthisis two years after giving birth to her.”

I have seen several cases of local bleaching of the eyelashes, more or less similar to the one recorded above. Mr. Waren Tay has shown me at least one such case. I possess a good

portrait illustrating this condition in a man who had suffered from a very peculiar form of destructive iritis. He had lost both eyes, and in both upper eyelids, placed quite symmetrically, there were tufts of white eyelashes. His eyebrows and the rest of his eyelashes remained of their natural brown tint. There can be little or no doubt that these changes are brought about from lesions of the nervous system, and in that relation they are of great interest.

No. XCVII.—*Ventral Hernia in an Infant.*

A very unusual form of hernia in an infant was brought to me in the winter of 1892; the infant was in good health and otherwise well formed: it was six months old. The hernial protrusion was as large as the child's fist, and contained intestine, which was easily returned, but which was extruded again immediately the pressure was removed, the aperture being large. It came directly through the abdominal wall on the right side, a little above, and internal to, the anterior superior spine of the ilium. It appeared to be external to the border of the rectus. I do not know of any anatomical explanation of the occurrence of a congenital hernia in this position, and I never saw one there before.

No. XCVII.—*Extreme Obesity in a Woman.*

I saw in the Infirmary at Kensington, under Dr. Potter's care, a remarkable example of obesity in a woman. She was only just able to walk about, and presented the closest resemblance to portraits of Daniel Lambert that I have ever seen. The accumulation of fat was especially great in the abdominal wall and the back and thighs. Her face did not show anything peculiar. She told me that the tendency to fatten was in her family, that her mother was very stout, and that she had a sister only a little less stout than herself. As a girl she was thick-set and rather stout, but not unusually so. At the time of her marriage she was not, she thought, at all particularly stout. She had borne a very large family of children, but, with the exception of the first two, had not been able to nurse any of them. She considered that the tendency

to put on fat had been especially great soon after her confinements: She had never taken much malt liquor, but had been especially fond of farinaceous articles of food, potatoes in particular. She was a cheerful, intelligent woman, aged about 45. Her obesity had disabled her from all domestic occupations, and obliged her to leave her family in the care of others and come into the workhouse.

No. XCVIII. — *Long recognised Enlargement of Spleen with Leuco-cythemia.*

I saw in the Kensington Infirmary, under Dr. Potter's care, an old woman who had been for many years the subject of enlarged spleen. She was about 63 years old, and had been born in Aylesbury, but had lived the greater part of her life in London. She was not aware that she had ever been exposed to the risk of palludism; she considered herself in good health, if it were not for the tumour, but she was extremely pale, her ocular conjunctivæ being absolutely white. Dr. Potter told me that the proportion of white corpuscles in her blood was definitely increased. The spleen could be felt, or almost seen, passing down from under the ribs to the iliac crest. It was extremely hard, and much more nodulated than is usual with the ague-cake. She told us that the presence of the enlarged spleen had been recognised by various medical men during at least six years.

No. XCIX. — *Persisting Acro-dermatitis allied to Chilblains.*

A curious form of acrodermatitis was shown to me in the person of a young lady, Miss W—, aged 27; she was in good health, and had a fairly vigorous circulation, and never suffered from cold hands or feet. In March, 1885, she had, after an attack of diphtheria, some little red spots on the tips of her fingers, for which she was for some time under the care of Dr. Bowles, of Folkestone. When she got rid of them she remained free until October, 1892. At this date her fingers became swollen and tender, but there was no itching like

that of chilblains, and there was no affection of her feet. The condition lasted more or less during the next three months, and up to the date of my consultation, January 18th. On this occasion I found the fingers generally red and a little swollen, but I was told that they varied very much, and were at times much more so. There was nothing that could be identified as a chilblain. I have little doubt, however, that the disease, although peculiar, should be recognised as belonging to the chilblain group.

No. C.—*Selected Paragraphs from a Commonplace-Book.*

It may be suspected that almost all that we name inflammation, more especially in its chronic forms, is, on the part of the organism, an obscure effort of growth.

We often, in describing what we suppose to be the features of a disease, describe really the peculiarities of the individual.

Chronic rheumatic arthritis often takes its local habitation from an accident, whilst its name is from the diathesis.

A remarkable example of symmetry is afforded in the moulting of birds. The large wing-feathers are always shed in pairs, the corresponding ones in the two wings falling out within a day or two of each other. This of course tends to keep the wings of equal power in flight. The symmetry in turn is, however, approached more or less closely by the other feathers.

Eruptions which come suddenly, go away of themselves, and often recur, are either herpetic or catarrhal, or it may be both.

Do not name symptoms as if they were diseases.

Speak very cautiously of species in disease, and avoid altogether such expressions as *sui generis*.

Seek for causes rather than for names.

We must analyse, and seek to interpret partnerships in disease.

“Species is merely an abstraction of the human intellect, not a real boundary set by nature.”

The recollection of this is yet more important in the investigation of disease than it is in zoology.

No. CI.—*Recurring Ophthalmitis with Opacities in the Vitreous—Mabey's Malady.*

Under the name of “Mabey's Disease” I have described certain very peculiar cases in which, in young persons, recurring attacks of iritis occur, attended by the formation of opacities in the vitreous, and resulting very frequently in entire loss of the eye. The disease appears to be definitely in association with the inheritance of gout, and the affection of the eye is usually accompanied by chronic disorganisation of the last joints of the fingers—acro-arthritis. This condition of the fingers ought, indeed, always to accompany an ophthalmitis in order to complete the picture of Mabey's malady.

I ought to add that liability to chilblains, feeble circulation, and tendency to tuberculosis, often enter into the partnership causation of this disease. The affection of the eye is, however, obviously its most conspicuous and important feature. In the following case, as yet, one eye only has suffered, and there is no disorganisation of the digital joints. There is, however, a known history of gout.

Miss D—— is a very pretty girl, of fair skin and blooming complexion, aged 21. One of her brothers is threatened with phthisis, her father was always very delicate, and she herself has never been robust although not definitely ill. She has for some years used glasses for hyperopia, and with them could see well with both eyes. About eighteen months ago her eyes began to suffer from attacks of irritability, and would ache and appear bloodshot. The condition often caused her for a few days to desist from reading for pleasure, but was never sufficiently severe to make her give up her duties as a

governess. Her right eye suffered most, and about a year ago she found that its sight was failing, and began to notice moving films in front of it.

It was with the above history that Miss D—— was sent to me on January 18, 1893. There was no redness of either eye when I saw her. She could with her glasses see perfectly with the left eye, but with the right only  $\frac{2}{3}\frac{0}{10}$ , and barely that. The cause of her defect was easily discovered by the ophthalmoscope, for the vitreous was full of large floating films. The retina and disc could be seen, but in a very hazy manner. There were no iritic adhesions nor any pigment spots on the lens, but some very delicate striæ were observed in the periphery of the latter.

On my making inquiries as to arthritic affections, Miss D—— told me that she often suffered from pain and slight swelling in the joints of her fingers, both in the terminal ones and the next to them. No permanent changes had, however, been produced. She occasionally had rheumatic aching in her shoulders, &c., but she had never suffered from any severe form of rheumatism. I already knew more of her family history than she did, for it so happened that I had personally known her grandfather. She entirely denied any history of gout, but I knew that he used to suffer from it, and this her mother (his daughter) confirmed. Miss D—— had herself always abstained from stimulants, and there was not the slightest reason to suspect any acquired gout or tendency to lithiasis in her.

No. CII.—*Molluscum Contagiosum from use of the Turkish Bath.*

It is many years ago since I was struck by the fact that men who are in the habit of using the Turkish bath sometimes become the subjects of molluscum contagiosum on the trunk. At different times I have published several cases. In one instance my doing so gave great offence to the proprietor of the bath, and a correspondence ensued in which it was strongly denied by him that such cases were ever noticed among his clients. A few weeks ago, however, a gentleman

consulted me about some symptoms which induced me to request him to undress, and I then found that he had scattered over his chest and back a number of the little buttons of *molluscum contagiosum*. On my drawing his attention to them, he said, "Oh! those are nothing; they are merely due to a Turkish bath." I asked him who had told him so; and he replied that the attendant at the bath had said that he frequently saw them.

No. CIII.—*Senile Freckles occurring on the right side.*

I may add another fact as to senile freckles in the case of an old lady named H——. She has now, at the age of 71, extremely dark pigment-stains on her right lower eyelid. There is also a continuous crescentic patch curving up the right side of her nose round the inner canthus, exactly in the position where the xanthelasma patch so often occurs. There is, however, not the slightest trace of xanthelasma. It is deep-brown staining of the skin, and nothing more. According to what appears to me to be the rule, it must be noted that it is on the right side, the reverse of what usually occurs in xanthelasma.

Mrs. H—— has enjoyed good health through life, and has never suffered from liver disorder. There is a slight appearance of staining on the left, but not approaching that on the right.

No. CIV.—*On Simulations of the Ivory Patch of Morphœa.*

The conditions which constitute what is called the "ivory patch" in morphœa are usually definite and unmistakable. The expression is very appropriate, for the patch does look exceedingly like discoloured ivory. Sometimes it is of a dead white, at others bluish, but more commonly of a yellowish tint. Its margin always thins off gradually into the surrounding skin, and it is always thickest in its middle. I have met with but a very few cases in which I have had difficulty in deciding whether any given patch was an ivory

patch or not, and due attention to the points alluded to have usually been sufficient to decide them. Certain very white and slightly thickened scars offer the conditions which most usually present difficulty. The true "ivory patch" has nothing in common with a scar, and when it disappears leaves no scar behind it. It is probably due to a temporary occlusion of the vessels of the part, and to effusion into the perivascular spaces. It never shows any tendency, after once being well developed, to spread at its edges. I have often taken occasion to insist on this as a very important characteristic, and as proving that the process which attends it is in no degree infective. Several writers have asserted that there are exceptions to this, but the disaccordance of opinion results, I feel sure, from not having waited to allow the full development of the patch. The stage of development lasts one or two months, and after that is well past there is, according to my experience, never any aggressive spreading. It is quite possible that some of the cases which have been described as showing a tendency to spread on the part of the ivory patch, may have been examples of the simulations which I am about to describe, rather than the true ivory patch of morphœa.

I have at present under care a lady, the subject of lupus erythematosus, whose cheeks well illustrate the condition to which I have referred. Every time I see her, the thought occurs to me "those must be morphœa patches;" and I am obliged to look at them again and again to convince myself that they are not so. She is a florid lady of very fair complexion. In the middle of each cheek she has a patch somewhat larger than a shilling, exactly like a piece of inlaid ivory. The patches are smooth, glistening, and slightly yellow. They are really scars, for they have followed the cauterisation which I made more than a year ago. The lupus process has ceased to spread, and may in a certain sense be considered cured, but there is still some tendency to the formation of little discs on other parts of the face. In two or three other cases in which lupus erythematosus has been cured by cauterisation with acid nitrate of mercury the scars are smooth and glistening, and might easily be

mistaken for those of morphœa. The most remarkable instance of this deceptive similarity which I have seen has occurred in a young woman who was sent to me by my friend Dr. P. S. Abraham. Although in her case differences of opinion have been expressed, I feel confident that the disease is really lupus erythematosus and not morphœa. As in the first case I spoke of, the conditions are symmetrical, and the middle of the cheek is the part affected. Exactly in the centre of each "flush-patch" of the cheek there is a round shilling-sized area like ivory. The reasons for believing that these patches really result from lupus erythematosus, and not from morphœa, are the following. Their margins are distinctly erythematous and slightly swollen, and there are some little red discs close to them (satellites), which she says well represent the early stage of the patches on her cheeks. There is also some roughness over the whole of the bridge of the nose, and the patient states that she had formerly patches in that position. The state of the little discs mentioned is characteristic of that of lupus erythematosus, and not at all that of morphœa. It is only, therefore, in the stage of retrogression, and scar, that the latter is simulated. There is, however, a further item of evidence. The patient suffers very much from chilblains. Her fingers are covered with erythematous papules, some of which present depressions in the middle. This is a valuable item of corroborative evidence.

No. CV.—*Note on the difficulty of effecting complete removal of the Nails.*

In a paper read last November before the Royal Society by Dr. F. A. Dixey, attention is asked to the fact that the corium underlying the epithelium of the nail is continuous with the periosteum surrounding the distal extremity of the ungual phalanx, and that the two structures are histologically very similar to one another.

This anatomical fact may perhaps account for the extreme difficulty which exists, especially in children, in completely extirpating a nail. I had recently occasion to attempt this

in the case of a girl in whom I was told that two operations had failed. Although, as the operator told me, he had taken the utmost pains to secure removal of the entire nail, fragments of a new one had been reproduced, and as they had again inflamed and become painful, I was asked to attempt it the third time, on account of the disappointment which had been encountered. It may be understood that under such circumstances I took especial care to excise the whole. The child was under an anæsthetic, and the circulation being controlled by an indiarubber band the dissection was not obscured by blood. I removed, as I thought, everything down to the bone, and in parts even took portions of periosteum. At the sides I left nothing that could be suspected to be nail-bed. In spite, however, of all my precautions the wound was no sooner healed than the scar, at several different points, began to form nail. It was not very much, but enough to be quite definite and to cause some irritation.

No. CVI.—*Indian Ringworm on thighs—Subsequently Pruriginous Dermatitis—Temporary cure—Relapse and slow development, during ten years, of incurable and almost universal Dermatitis—Finally, after fifteen years, the condition of Mycosis Fungoides—Note on the importance and peculiarity of the Gland disease attending that malady.*

A man named P—— came under my observation in June, 1886, whose case has subsequently assumed much interest as an example of what is now known as Granuloma fungoides. His condition when I saw him six years ago was that of general dermatitis of a mixed character, which had been intensely pruriginous and terribly scratched. He admitted that he sometimes spent half the night in scratching. He had spent a year in continuous treatment at Harrogate just before I saw him, and without benefit. Previous to that he had given up a good situation in Ceylon on account of the

incurability of his disease. He was thirty years of age, and married.

Mr. P——'s account of his malady was that he had in the first instance suffered from Indian ringworm, which was treated by Goa powder. This was followed by much irritation, and thirteen or fourteen years before I saw him patches developed behind one knee and on the tips of the elbows. A year later his palms were affected. In 1875 he left Ceylon, and, returning to England, put himself under the care of a specialist, who cured him completely for a time. His legs were at that time severely affected and much swollen. He had had much trouble from soreness under the edges of his nails. Early in the case the glands below the groins had become enlarged.

My notes describe Mr. P—— as suffering from an eczematous form of lichen, with extensive changes caused by scratching. The skin of his lower extremities was thickened, and there were long, narrow ridges, almost keloid in character. His face was not much affected and never had been, otherwise the dermatitis was nearly universal. On the hands it was definitely eczematous. He complained of a distressing sensation, as if coated with clay which had dried on him. His health was still good, and he said that prior to his skin disease he had always been strong.

It will be seen that although according to his statement the affection of the skin had begun as early as the age of seventeen, yet it had for many years given but little trouble, and had not been any bar to his marriage. That it had been severe at the age of twenty was, however, proved by his having come over to England for treatment. The enlargement of the femoral glands was unusually great, and the mass on the right side was so large that I advised their removal. They were, as usual, loose and had no tendency to inflame. They were excised by his own surgeon, or at any rate most of them were removed.

Mr. P—— at the present date (January, 1893) is still the subject of diffuse dermatitis, with much general thickening of skin and many little papular or even nodular indurations. He has several patches on his forearms, &c., which present

some tendency to fungate, but are for the present quite low and quiet. He is still in fair health, though he has lost flesh. There are large gland-masses in his groins.

I publish this fragment as a contribution to our knowledge of the early stages of the form of dermatitis which sometimes after many years furnishes examples of the fatal malady known as mycosis or granuloma fungoides. Most but not quite all of these are, as in this instance, exceedingly pruriginous and much aggravated by scratching. They are not to be distinguished by any definite feature from other forms of pruriginous eczema. Nor are they in their early stages incurable. The dermatitis is, however, very prone to develop, and in the end the patient's uncontrollable proclivity to scratching produces conditions which no treatment can overtake. By far the most definite condition which marks out a case of pruriginous dermatitis as likely to end in mycosis fungoides is the enlargement of the lymphatic glands. The kind of enlargement of them is peculiar. They are not inflamed, nor in the least painful, but remain soft and fleshy, quite distinct from each other and loose under the skin. The glands of the upper part of the thigh are those usually affected, and their position is also peculiar. They occur at some little distance below Poupart's ligament in the apex of Scarpa's triangle. They cause the patient no inconvenience excepting by their size, and they remain quiescent by slowly increasing for many years together. I never see a patient with enlarged glands in this position and of this character in association with eczema, without forming a very unfavourable opinion of his prospects. Almost all the cases which I have seen have been in men.

## A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

### No. CLI.—*Fracture of the Leg.*

A man had his leg broken by a kick from a horse. The bones are now strongly united, but with great ovoid swelling in the lower part of the leg. The leg is nearly two inches shorter than the other. The lower end of the upper portion of the fibula projects sharply under the skin about six inches above the tip of the inner malleolus.

#### QUESTIONS.

1. What was probably the character of the fracture?
2. Is it correct to speak of the ovoid swelling as being caused by provisional callus?
3. In what respect was the treatment of the case defective?
4. Is the displacement which has occurred that which is usual?

#### ANSWERS.

1. Both bones were broken: and from the nature of the violence, as well as the present condition of parts, it is extremely probable that there was comminution.

2. The swelling is due to the fact that the bones overlap each other, and that very probably some small comminuted fragments are placed across the line of the principal fracture. There is nothing of the nature of "provisional callus," which, as a matter of fact, occurs only in intraperiosteal fractures.

3. The defects in treatment were (1) that no real reduction was ever accomplished, and (2) that extension was not efficiently kept up.

4. There is no rule as to the displacement in cases of

fracture by direct violence, such as this was; the bones pass in such direction as the violence drives them.

### No. CLII.—*The Circulation.*

1. What is meant by the expression “equalise the circulation”?

2. Mention some of the chief influences by which the due balance of the circulation may be disturbed.

3. What is meant by the expression “determination of blood to a part”?

4. Is it correct to speak of active and passive determination of blood?

5. What are the usual results of long continued, or often repeated, determination of blood?

6. What is the meaning of the expression “ubi irritatio ibi fluxus”?

7. Mention a good example of hypertrophy from determination of blood.

#### ANSWERS.

1. The expression is a very good one (although not much now in use) to denote the measures of treatment which favour the equal distribution of blood to all parts of the body.

2. Exercise stands in the very foremost place, and, on the contrary, all sedentary habits favour local congestions. A large number of drugs, especially those of the stimulant class with alcohol at their head, are, when judiciously used, very efficient in this direction. They favour the relaxation of arteries, and increase the vigour of the heart. Their effect is, however, less lasting than that of exercise, and, when it passes off, may be followed by a reverse condition. External heat is a powerful equaliser—such, for instance, as the hot bath. Heat applied locally, as, for instance, the pediluvium, is a very efficient means of counteracting a local congestion.

3. It means enlargement of the calibre of the arteries, and consequent increase of quantity of blood in the part supplied. It occurs in many conditions of functional activity, and in all congestions and inflammations.

4. The term “determination” should be restricted to

conditions in which some active influence is at work ; other states may be spoken of as passive congestions.

5. Determination of blood, if slight in degree, will promote function and growth. If the latter passes beyond the limits of health, it would receive the name of "hypertrophy." If excessive, and especially if the blood-vessels be weak, determination may often result in rupture and hæmorrhage.

6. The expression denotes a general fact that the irritation of any part has the effect, through the nervous system, of producing local relaxation of the arterioles and increased supply of blood. The congestion of a flea-bite or a chilblain are fair examples.

7. The best example that can be given is elephantiasis in its various forms. Elephantoid hypertrophy is usually the result of repeated attacks of determination of blood from erysipelas. Other conditions, such as lymphatic obstruction, usually complicate the result ; but undoubtedly the main cause of the overgrowth is repeated determinations of blood.

### No. CLIII.—*Hemi-atrophy of Face and Facial Paralysis.*

I extract the following from a recent number of a medical journal:—"He also showed a baby with facial paralysis, the result of injury received at birth from the use of forceps, only noticeable when the child cries. This condition often leads to a permanent semi-atrophy of the face."

#### QUESTION,

Is the last part of this statement correct ?

#### ANSWER.

No : the facial nerve (*portio dura*) is not a nerve having any influence over the nutrition of the parts supplied ; its injury might leave the cheek baggy and loose, but would not in any way interfere with the growth. The cases of so-called hemi-atrophy of the face, which the writer of the paragraph probably had in his mind, are consequent upon disorder of the vaso-motor fibres, which travel chiefly with

the branches of the fifth. Hemi-atrophy is a consequence of morphœa (sclerodermia), but not of facial paralysis.

#### No. CLIV.—*The Abortive Treatment of Syphilis.*

##### QUESTIONS.

1. The term "abortive treatment of syphilis" is used by writers with reference to two different procedures. What are they?
2. What are the objections to the first of these?
3. Is the second of them practicable?
4. What are its details?
5. What directions are to be given to a patient as regards diet, &c., during a long course of mercury for this purpose?

##### ANSWERS.

1. By some the abortive treatment of syphilis is understood to mean the prevention of its development by the excision or destruction of its primary sore. By others the same term is used in reference to the prevention of the development of the disease by a course of mercury commenced as soon as the primary sore can be diagnosed.

2. It is scarcely ever efficient. By the time that an infecting chancre can be recognised as such, the virus has almost always passed into the lymphatics, and the excision of the original sore results only in disappointment.

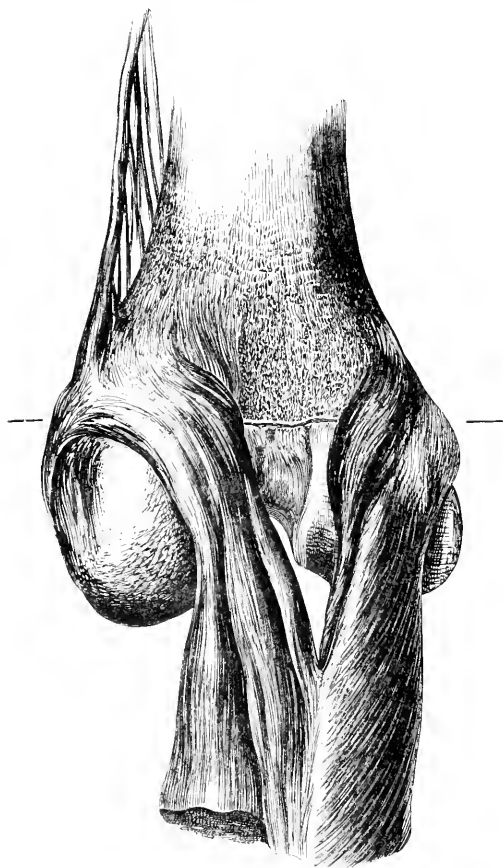
3. It is quite certain that the careful and efficient use of mercury, begun before any secondary symptoms have appeared, will in a large majority of cases entirely prevent their appearance, and thus abort the malady.

4. This abortive treatment by mercury may be carried out in many ways; but the most convenient is the use of grey powder in one-grain pills, in combination with opium. Of these the patient should take as many as he can bear without inconvenience from either ptyalism or diarrhœa. They may be taken three, four, five, or even six times in the twenty-four hours.

5. The chief difficulty in the treatment is to prevent diarrhœa, and with this object the most explicit directions

should be given, and insisted upon, as regards diet. The patient should take no green vegetables, soups, made dishes, coffee, or malt liquor. No stimulant is to be allowed, except a little spirit and water, brandy by preference.

No. CLV.—*Detachment of Lower Epiphysis of Femur.*



QUESTION.

In this woodcut we have represented the back of the femur, showing the attachment of the two heads of the gastrocnemius muscle and the line of the epiphysis. It will be seen that

the muscle is attached almost wholly above the epiphysal line. In a previous number of the ARCHIVES (see Catechism, page 287) it is stated that the lower epiphysis after detachment may be drawn backwards towards the popliteal space by this muscle. How can such a description be reconciled with the anatomical fact? Apparently it would be the lower end of the shaft upon which the muscle would act.

## ANSWER.

It must never be forgotten that in all detachments of epiphyses the periosteum is extensively stripped, like a sleeve, from the lower end of the shaft: the latter is left quite bare. The periosteum sleeve, with which, of course, go all attached muscles, becomes, as it were, a part of the epiphysis, and thus permits the muscle to displace the latter.

No. CLVI.—*Congenital Tumour.*

This woodcut shows an infant affected by a large tumour of the sacral region.

## QUESTIONS.

1. Are the appearances more suggestive of spina bifida, or of what is known as the "coccygeal tumour"?
2. What is the nature of the "coccygeal tumour"?
3. May they be removed with safety?

## ANSWERS.

1. From its dependent position and large size it is quite certain that the tumour is not a spina bifida. The cyst of a spina bifida is usually placed exactly in the middle line over the upper part of the sacrum, and seldom or never becomes so dependent as to be in the least visible from before. The position of this mass marks it clearly as an example of what is called a coccygeal tumour.

2. Coccygeal tumours may in very rare instances contain parts of an included fœtus. More usually they are examples of a peculiar cystic and solid growth, developed from embryonic tissue, between the coccyx and the rectum. They may possibly have their origin in the structure known as Luschka's gland. They sometimes envelop the coccyx and drag down and displace the rectum.\*

3. These tumours, although large and very formidable, may often be removed with safety. They are loosely attached and do not pass upwards into the pelvis. Care must be taken not to injure the bowel. Such operations should not be undertaken during the first months of life.

No. CLVII.—*Symptoms in Joint Disease.*

## QUESTIONS.

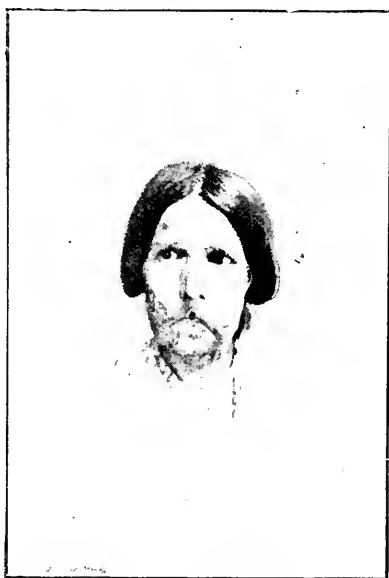
1. Mention one of the earliest symptoms of chronic rheumatic arthritis commencing in the shoulder-joint.
2. Mention one of the earliest symptoms of chronic rheumatic arthritis commencing in the hip-joint.

\* For a description with good illustrations of appearances both during life and after dissection, see my "Illustrations of Clinical Surgery," vol. ii. p. 35. In Plate 49 of that volume the relations of the tumour to the bowel are well shown.

## ANSWERS.

1. One of the earliest symptoms and one of the most constant, when disease is commencing in the shoulder, is inability to put the hand behind the back. A man complains that he cannot button his braces, a woman that she cannot lace her stays.

2. One of the first symptoms in reference to the hip-joint is difficulty in getting at the foot. The patient finds himself obliged to resort to artifice in order to put on his boots. Very often this has come on so gradually that it has scarcely been noticed, but, if the surgeon inquires about it, will usually be at once admitted.

No. CLVIII.—*Cicatricial Contraction of Mouth.*

## QUESTIONS.

1. What is the condition shown in the above illustration?
2. Of what disease is it probably the result, and what would be the appropriate treatment?

## ANSWERS.

1. The woman's mouth is so far closed by cicatrix after

destruction of the lips that it would barely admit a large pencil. The scar may have been consequent on several different forms of destructive ulceration, sloughing after a burn, cancrum oris, &c. It is, however, extremely improbable that from either of the two causes suggested such peculiar puckering up of the mouth would result. Sloughing from either of these causes would probably involve the whole thickness of the lip and cheek, and leave a large gap instead of a contracted orifice. The peculiar contraction present suggests that not the whole thickness, but only the skin surface of the lips, &c., was destroyed.

2. The only disease likely to have done this is lupus (it was from this affection that the woman had suffered). It will be seen that a superficial scar extends over the chin and on to both cheeks. The treatment most likely to succeed would be by moderate incisions on both sides, and then, if possible, bringing the mucous membrane from within to cover the cut edges.

### No. CLIX.—*The Mammilated Pharynx.*

#### QUESTIONS.

1. Our forefathers used to speak of the “mammilated pharynx ;” what are the modern terms in use for the condition so named ?
2. Describe the physiognomy of a patient suffering from these growths.
3. Is the condition an important one, and what symptoms may it produce ?
4. Is it to be regarded as an indication of diathesis, or as a result of disease ?
5. What are the measures of treatment ?

#### ANSWERS.

1. The term “mammilated pharynx” was formerly applied to the little reddish granulation-like masses so often seen scattered over the upper part of the pharynx in young persons. They are now known as adenoid growths, and usually imply the presence of yet larger ones concealed above

the palate. To the latter the terms "post-nasal growths" or "adenoid vegetations" are often given.

2. The growths, if considerable, cause obstruction in the naso-pharynx, and this causes the patient to keep his mouth open in order to breathe, and a more or less dull and stupid expression is assumed.

3. It is believed that not only does the patient look dull, but that he becomes really so. This may be partly due to the deafness which attends the malady, and partly to the fact that, never being in perfect comfort, it is difficult for him to give efficient attention to anything; they may also, by interference with respiration, cause definite injury to the general health.

4. In the first instance they are undoubtedly to be regarded as indications of diathesis or of family tendency, but they may subsequently, in such connections as chronic catarrh, &c., become the seats of disease.

5. Their removal by operation is by far the simplest measure, and should never be neglected. It is easily effected by specially contrived forceps, or even by the surgeon's finger-nail.

The complete clearing of the patient's throat and nasal pharynx from enlarged tonsils and these adenoid growths may be the means of effecting a most satisfactory change in the child's health, comfort, physiognomy, and even character.

## No. CLX.—*Modes of introduction of Syphilis.*

### QUESTIONS.

1. Mention the principal means by which syphilis may be initiated.

2. In addition to the four which have been named, is it probable that there are any others; more especially, what is your theory as regards the not very infrequent cases in which no chancre is ever recognised?

### ANSWERS.

1. Syphilis may be produced—

(1) By contagion from a chancre (whether with abrasion or without). A chancre results.

(2) By contagion from a secondary sore secreting pus (with or without abrasion). A chancre results.

(3) By contagion from the blood of an infected person. A chancre results.

(4) By the placental contact of the blood of a mother with that of her fœtus. No chancre occurs.

2. It must be admitted to be possible that the introduction of the blood of a syphilitic patient directly into the blood vessels of another might produce syphilis without any antecedent chancre. In practice, however, such an occurrence is barely possible. As regards the occurrence of syphilis without chancre, it is to be admitted that primary sores may vary very greatly in their appearances, and may sometimes be exceedingly inconspicuous. These differences probably depend in part upon the idiosyncrasies of the individual, in part upon the mode of contagion, and in part upon the structure of the tissue inoculated. It must be freely admitted that it is possible for the virus of syphilis to be absorbed without the occurrence of any ostensible chancre.

## No. CLXI.—*On Circumcision.*

### QUESTIONS.

1. Under what circumstances is the operation of circumcision in infancy desirable?
2. How should it be performed; ought stitches to be used?
3. What special risks attend it?

### ANSWERS.

1. It is imperatively required whenever the prepuce is unusually long and contracted at its orifice. The surgeon should, however, avail himself of every possible opportunity of inducing parents to have their male children circumcised. The operation confers great advantages in several different directions. If properly done, it has no drawbacks whatever.

2. For the performance of circumcision, the surgeon should be provided with two pairs of straight scissors—one large, the other small. Drawing the prepuce a little forward, he should include all that is in front of the glans between the

handles of his smaller scissors, and nipping it tightly, should then with the larger ones cut all the projecting part away. This will remove a broad ring of skin and leave the glans covered only by mucous membrane. Next, with his smaller scissors, he should slit up the mucous membrane and cut it cleanly away level with the corona. Not more mucous membrane than a strip of about one-eighth of an inch in width should be left. If any adhesions are present they should be carefully broken down. What remains of the frænum may now be tied; no other vessels will need attention. Stitches are quite unnecessary, and generally inconvenient and injurious.

3. By far the most important risk is that of hæmorrhage, and very careful attention should be given to the ligature of the frænum. Many children have died after the operation in consequence of carelessness in this matter. The only other risks are poisoning of the wound by unclean instruments, and the introduction of syphilis by the dressings, &c.\*

## No. CLXII.—*Variolation and Vaccination.*

### QUESTIONS.

1. What is the difference between vaccination and variolation?
2. Is it probable that variola can be transmuted into vaccina?
3. What is meant by the term "vaccinia eruption"?
4. What are the chief differences between the pock produced by variolation and that of vaccination?

### ANSWERS.

1. By vaccination is meant the introduction of a virus derived, directly or indirectly, from pocks on the udder of

\* In my work on Syphilis I have recorded a series of cases, in which a Jewish circumcisor communicated syphilis by unclean lint. I have recently been consulted in a case in which, in all probability, an operating surgeon did the same by his instruments.

the cow.\* Variolation is inoculation with small-pox matter derived from the human subject.

2. It is probable that all vaccine lymph is derived from human variola transmuted by passage through the system of a cow.

3. In not a few cases after successful vaccination an eruption appears on the child's body from the eighth to the fourteenth day. This eruption may vary a good deal in character. It is usually symmetrical and vesicular. In rare cases it may closely resemble variola. To this eruption, whatever appearance it may assume, the term "vaccina rash" is applicable. It is the exanthem of the vaccination fever, and the wonder is that it should not be present in all cases.

4. The two pocks very closely resemble each other, and as regards dates, they run an almost parallel course. Their chief difference is that, while those of vaccination remain single, however much the inflammation of the arm may be, those of variolation are constantly attended by the formation of little satellites around their margins, which often, at a later stage, coalesce with the parent pock.

## No. CLXIII.—*Elephantiasis and Hypertrophy.*

### QUESTIONS.

1. What is the condition of the arteries in a limb affected by elephantiasis?

2. Of what inflammatory affection is elephantoid hypertrophy the ordinary result?

3. Is there any real difference between elephantoid hypertrophy and true elephantiasis?

4. What parts are most usually the seats of elephantiasis?

5. Is there any real difference between hypertrophy of scars and keloid?

\* The term "vaccination" has been much widened by modern experimenters, as it is now used to include the purposeful inoculation with any virus which is supposed to have been attenuated.

## ANSWERS.

1. The arteries are always dilated, and their dilatation attended by thinning of the coats: this is especially definite in the case of the femoral arteries, and constitutes an important source of danger.

2. Most cases of elephantiasis begin in erysipelas: it is often a consequence of slight wounds or abrasions.

3. There is no real difference between elephantoid hypertrophy and "true elephantiasis." What is called elephantoid hypertrophy is usually only a slight form or an early stage of what, when well-advanced, every one would call elephantiasis.

4. Elephantiasis is usually developed in parts which are more or less independent, and which, as a consequence, do not readily relieve themselves from œdema. The legs and the genitals in both sexes are the regions which are its most frequent seats. It is very rarely seen in the upper extremities, but the lower eyelids and the lips may occasionally become its seats.

5. As there is only a difference in degree, or perhaps in the stage of development, between elephantoid hypertrophy and elephantiasis, so also hypertrophy of scars is only a stage or degree of keloid. We find keloid to be fibroid hypertrophy of scar tissue; it may vary very much in the characters it attains to in different cases.

No. CLXIV.—*The Cause of Conical Stumps.*

Richter records of a case in which he had amputated through the thigh: "I saw the patient eighteen months after, and, to my great astonishment, found that all the muscles round the bone had retracted in such a manner that the bone projected a whole handbreadth, covered only with the skin."

## QUESTION.

What was probably the age of Richter's patient?

## ANSWER.

The cause of conical stump is almost always the growth of the bone subsequent to the amputation. It grows, of course,

from the epiphysis above. We may therefore always infer, respecting a case in which a stump has become conical, that the patient was young. (Richter's patient was a lad of fourteen.)

### No. CLXV.—*Missing Words.*

To test his knowledge of the History of Medicine, the reader is requested to supply the omitted names in the following quotation:—

“The first Physicians had but a very faint notion of the Brain presiding over the Animal system by the Mediation of the Spinal Marrow and Nerves produced from it, and distributed to the rest of the Body. And we must acknowledge this was not sufficiently understood before                      and                      , the greatest Anatomists of Antiquity, who explained this Scheme and left the World no Room to doubt of this elegant Piece of Mechanism of the animal Body. Physicians began to dissect with more than ordinary care both living and dead animals; and they soon found that by cutting, tying, or compressing any Nerve, or any other way intercepting its Communication with the Brain, the Parts to which it belonged were immediately deprived of all Sense and Motion.

“It was easy to confirm this Doctrine by experiments on any of the ordinary Nerves. But one of the prettiest Instances of it, was the making Ligatures upon the Vessels at the Side of the Wind-pipe, and immediately striking the Animal dumb, however noisy it was before. The first Makers of this experiment thought the Animal turned comatous, or fell asleep; and ascribing this Effect to the intercepting any Passage of vital Blood from the Heart to the Brain, by the Way of the Arteries; they gave these Blood Vessels the Name of *Carotids*, *καροτιδῶν*. But in the days of                      , this sudden Silence of the Animal was found to proceed from the tying of the adjacent Nerves, and                      , who seems to have laboured this Affair more than any of his Predecessors, evidently proved, that tying the Arteries solely produced little change on the Animal. In this Case (laying aside the





## PLATE LXXII.

### AN EXCEPTIONAL FORM OF LUPUS.

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THIS portrait represents the face of a woman about fifty years of age, in whom the disease had existed only six months. The disease was, I believe, essentially lupus vulgaris, but presented exceptional features and had spread with immense rapidity. There was no reason whatever to suspect syphilis. The disease had commenced in the middle of the flush-patch of the cheek, and with so much inflammatory induration that it was at first suspected to be carbuncular. After a little time the swelling subsided, and the disease lapsed into a chronic form and spread by contagion-of-continuity at its edges. At the same time a satellite sore was developed on the forehead. There was no implication of the lymphatic glands, and the mode of spreading was quite characteristic of lupus. There was never at any time anything which could be recognised as "apple-jelly growth." Great benefit was obtained by free canterisation with the acid nitrate of mercury.







## PLATE LXXIII.

### THE SEBACEOUS FORM OF LUPUS ERYTHEMATOSUS.

*(Copied from Hebra's Atlas.)*

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LUPUS ERYTHEMATOSUS presents itself in different forms. In some cases the parts implicated present erythematous congestion almost solely. (A good illustration of this is given in the next Plate). In others there is an extensive implication of the sebaceous glandular system. Comedones are frequently found, and the patches are roughened over, like a piece of orange-peel, by the open orifices of glands and little plugs of dried sebum. The portrait which is given in this Plate is one which I have copied from Hebra's Atlas, because I do not myself possess one which so well illustrates the combination of conditions characteristic of the sebaceous and erythematous form. In many cases of lupus sebaceus the disease remains long limited to the nose, and but rarely assumes the bat's-wing form, or becomes accurately symmetrical. Thus it would appear to be a sort of connecting link between lupus vulgaris and lupus erythematosus. In this portrait, however, we see the disease very accurately symmetrical, whilst the implication of sebaceous glands is extensive and conspicuous. The margins of the patches consist of confluent groups of enlarged glands and are covered by dry seborrhaic secretion.







## PLATE LXXIV.

### THE ERYTHEMATOUS FORM OF LUPUS ERYTHEMATOSUS.



THIS Plate is the portrait of a boy who was the subject of the most superficial and purely erythematous form of lupus erythematosus. It will be seen that almost the whole of his nose is involved in erythema, and that bat's-wing patches extend symmetrically over both cheeks. There was little or no thickening, and only the slightest possible desquamation; and there is no evidence of special involvement of sebaceous glands. In this latter respect the case may be contrasted with the preceding Plate. It will be seen that on the boy's upper lip, close to the pro-labium, there is a half disc of erythema which shows more thickening than other parts. The development of satellite discs of this kind is, as all know, a very characteristic feature of the disease.









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